Your Dental Policy
From Delta Dental of New Jersey, Inc.
Delta Dental Individual- Basic Family PPO Plan I

Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, New Jersey 07054
1-888-899-3734
www.deltadentalcoversme.com
WELCOME

Delta Dental of New Jersey, Inc. (“Delta Dental”) welcomes You and the other Covered Persons You have signed up for coverage.

This Policy has facts You need to know. It includes information about Eligibility, Enrollment, Covered Services, Benefit Limitations, and Exclusions. Your rights under this Delta Dental individual dental Policy are also included. Please read it carefully and refer to it for questions about this dental coverage.

The terms “You” and “Your” means the person(s) who signed up for in this Policy. The terms “We,” “Us” and “Our” means Delta Dental. The capitalized words used throughout this Policy have specific meanings. The meanings of capitalized words are in the Definitions section of this Policy.

This Policy is issued by Delta Dental of New Jersey, Inc. and delivered in New Jersey. All terms, conditions, and other rules of this Policy are governed by New Jersey law for individual dental coverage. All Benefits are paid based on the terms, conditions, and rules of this Policy.

Policy service is provided by Delta Dental of Wisconsin, Inc. located at 2801 Hoover Road, P.O. Box 103, Stevens Point, WI 54481-0828.

For questions about this Policy, call Delta Dental Customer Service at 1-888-899-3734.
10-DAY RIGHT TO REVIEW AND RETURN THIS POLICY

Please read this Policy carefully. If You are not satisfied, You may return the Policy within 10 days after You received it. Mail it to Delta Dental along with your name and Delta Dental Member ID Number at the address shown below. Any Subscription Charges You paid will be refunded. If any Covered Person received Benefits during the 10-day period, Subscription Charges paid will be refunded to You less the amounts that We paid for Claims. If the amount of the claims paid is greater than the Subscription Charges paid, no refund will be issued. If You do not return it within the 10-day period, it means You accept the terms of this Policy.

POLICY RENEWAL AND SUBSCRIPTION CHARGES

You may keep this Policy in force by timely payment of Subscription Charges. But, Delta Dental may not renew this Policy on the following basis:
1. Non-payment of Subscription Charges. There is a grace period of thirty (30) days (ninety (90) days if You are getting a Premium Subsidy for this Policy) as noted in Section 4.3, or
2. Fraud or material misrepresentation made by or with the knowledge of a Covered Person applying for this Policy or making a Claim for Benefits under this Policy, or
3. A Covered Person engaging in intentional non-compliance with material rules of this Policy, or
4. Sending any Claim to Delta Dental which has a knowing misstatement of fact, or
5. Delta Dental ceasing to renew all Policies issued on this form to residents of New Jersey.

Delta Dental may not renew this Policy for the reasons above as of any Subscription Charges due date. Other than for reasons of insurance fraud, at least 90 days’ notice will be given for any non-renewal action under this provision. It will be mailed or e-mailed to Your last physical address or e-mail address in Delta Dental’s records. Other than for reasons of insurance fraud, if Delta Dental fails to give 90-days’ notice of non-renewal, it will stay in effect until 90 days after notice is given or until the effective date of any replacement coverage, whichever happens first. No Benefits will be paid for Dental Services incurred during any period for which Subscription Charges have not been paid; the only exception appears in Section 4.3.

THIS POLICY, INCLUDING THE DECLARATION, ANY WRITTEN AMENDMENTS TO THIS POLICY, AND YOUR COMPLETED APPLICATION ATTACHED TO THIS POLICY, MAKE UP THE ENTIRE AGREEMENT AND UNDERSTANDING BETWEEN YOU AND DELTA DENTAL OF NEW JERSEY, INC. ALL CHANGES TO THIS POLICY WILL BE COMMUNICATED IN WRITING IN ACCORDANCE WITH SECTION 4.6.

DELTA DENTAL OF NEW JERSEY, INC.
1639 ROUTE 10 P.O. BOX 222
PARSIPPANY, NEW JERSEY 07054

By: ________________________________
Vice President, Underwriting & Actuarial Services
Dental Program Overview

This overview has a general description of Your dental Policy. Use it as a helpful reference. Details of Your program appear in Section 7.0, “Schedule of Benefits.” Note that all terms in bold print are defined in Section 2.0. Adult Enrollees and Pediatric Enrollees (if applicable) receive different Benefits under this Policy. This overview generally describes each type of coverage. The details appear in the Policy.

This Policy will pay a Benefit only for Covered Services. Covered Services may not result in payment of a Benefit under this Policy due to Benefit Limitations and Exclusions. You are required to obtain a Prior Authorization from Us before a service is performed for some Covered Services for Pediatric Enrollees. Those Services are described in Section 10.2. Where Prior Authorization is required but not obtained, We can apply a penalty of up to 50% of the charges that would otherwise be covered.

Where a Dental Service is a Covered Service and We pay a Benefit for it, We base Our Benefit on the Allowed Amount for the Service. That is explained in Section 5.0. It will vary based on the actual fee the Dentist charges for the Dental Service. Our Benefit Amount will generally be the Allowed Amount times the Coverage Percent for the Covered Service. For example, if the Coverage Percent for teeth cleaning is 80%, We would multiply the Allowed Amount by 80% and would pay that amount, subject to the Benefit Maximum for Adult Enrollees which is listed in Section 6.6 or subject to the Cost Share Limit which is listed in Section 6.2. for Pediatric Enrollees.

You will pay the difference between the Benefit that We pay (which could be zero, depending on Benefit Limitations and Exclusions) and the Approved Amount for the Service. The Approved Amount for Network Dentists and for Delta Dental Participating Dentists is limited by Delta Dental and may be less than the Dentist would usually charge for a Dental Service. The Approved Amount for Non-Participating Dentists is the full amount the Dentist charges for the Dental Service.

Because We apply the Coverage Percent to the Allowed Amount, and because there are Benefit Limitations and Exclusions and Alternate Treatment Limitations that may apply to the Dental Service that You receive, We may pay no Benefit toward a Covered Service or, pay a Benefit that is less than the Coverage Percent of the Approved Amount. You should read the detail in Sections 7.0 and 8.0. As We note in Section 10.1, for Covered Services which do not already require Prior Authorization, We urge You to ask for a Pre-Treatment Estimate for Dental Services which cost more than $300. But You can also ask for one for Dental Services that cost less than that.
<table>
<thead>
<tr>
<th>Summary of Covered Services</th>
<th>Coverage Percent of the Allowed Amount Paid by Delta Dental*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive and Diagnostic Dental Services</strong> to check existing dental health and to prevent dental disease, such as exams, cleanings, and x-rays.</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Basic Restorative Dental Services</strong> to fix or repair teeth harmed by decay or fracture, such as amalgam and composite fillings.</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Crowns</strong> Repair of teeth with crowns when they cannot be restored with other filling materials.</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Endodontics</strong> The care of teeth with damaged nerves, such as root canal treatment.</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Periodontics</strong> The treatment of diseases of the gums and supporting bone, such as scaling and root planing.</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Fixed and Removable Prosthodontics Dental Services</strong> and appliances to replace missing teeth, such as dentures and bridges (excluding implants).</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Implants</strong> Implant Services for edentulous Pediatric Enrollees (otherwise implants are not covered).</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Adjunctive General Services</strong> Dental Services include consultations, general anesthesia, and palliative care (temporary treatment of dental pain).</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong> Tooth extractions and other dental surgery.</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Medically Necessary Orthodontic Services</strong></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Coverage Period Deductible (not applied to Preventive and Diagnostic Services)</strong></td>
<td>$135 per Pediatric Enrollee $405 for all Pediatric Enrollees</td>
</tr>
<tr>
<td><strong>Coverage Period Maximum Cost Share Limit</strong></td>
<td>$350 per Pediatric Enrollee $700 per two (2) or more Pediatric Enrollees</td>
</tr>
</tbody>
</table>

As noted above, the dentist a Pediatric Enrollee uses, the Deductible, Cost Share Limit, Specific Exclusions and Specific Limitations and General Exclusions can also affect the amount You owe. See Sections 6.0, 7.0, and 8.0 for details.
## SUMMARY RELATING TO ADULT ENROLLEES

<table>
<thead>
<tr>
<th>Summary of Covered Services</th>
<th>Coverage Percent of the Allowed Amount Paid by Delta Dental*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive and Diagnostic Dental Services</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Restorative Dental Services</td>
<td>60%</td>
</tr>
<tr>
<td>Crowns</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Endodontics</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Periodontics</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Fixed and Removable Prosthodontics Dental Services</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Adjunctive General Services Dental Services</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Coverage Period Deductible when services are rendered by a Network Dentist (not applied to Preventive and Diagnostic Services)</td>
<td>$75 per Adult Enrollee $225 for all Adult Enrollees</td>
</tr>
<tr>
<td>Coverage Period Deductible when services are rendered by a non-Network Dentist (not applied to Preventive and Diagnostic Services)</td>
<td>$100 per Adult Enrollee $300 for all Adult Enrollees</td>
</tr>
<tr>
<td>Coverage Period Annual Maximum when services are rendered by a Network Dentist</td>
<td>$1,000</td>
</tr>
<tr>
<td>Coverage Period Annual Maximum when services are rendered by a non-Network Dentist</td>
<td>$750</td>
</tr>
</tbody>
</table>

As noted above, the dentist an Adult Enrollee uses, the Deductible, Specific Exclusions and Specific Limitations and General Exclusions can also affect the amount You owe. See Sections 6.0, 7.0, and 8.0 for details. Implants and Orthodontic Services are not covered for Adult Enrollees of any age and not covered for Covered Persons age 19 and above.
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1.0 - USING THIS DENTAL PROGRAM

1.1 - About Delta Dental
Delta Dental of New Jersey, Inc. ("Delta Dental") is a New Jersey not-for-profit dental service corporation. Delta Dental is a member of the Delta Dental Plans Association. We cover people across the country with both individual and company-sponsored dental programs.

1.2.1 - Network Dentists in New Jersey
Your Policy lets You get Dental Services from any Dentist. However, You will maximize Your benefits under this Policy and may be able to reduce Your out-of-pocket costs if You choose to get services for Adult Enrollees and Pediatric Enrollees from a Network Dentist. Under this Policy, a Network Dentist is a Delta Dental PPO℠ Dentist and Delta Dental Participating Specialist. When Dental Services are provided by a Delta Dental PPO℠ Dentist, the percentage paid by Delta Dental is based on the least of the Dentist’s actual fees, the fees the Dentist filed with Delta Dental or the PPO Approved Fees. When Dental Services are provided by a Delta Dental Participating Specialist, the percentage paid by Delta Dental is based on the least of the Dentist’s actual fee, the fee the Dentist filed with Delta Dental or the Participating Specialist Maximum Approved Charge. Your out-of-pocket costs may be lower if You use a Delta Dental PPO℠ Dentist because the fee limits for Delta Dental PPO℠ Dentists are usually lower. However, Your Policy covers the same Dental Services whether or not You use a Delta Dental PPO℠ Dentists or a Delta Dental Participating Specialist. For further information, call Customer Service at 1-888-899-3734.

1.2.2 - Non-Network Dentists
You may get Dental Services from a Non-Network Dentist (a Delta Dental Participating Dentist or a Non-Participating Dentist). If You visit a Non-Network Dentist, You will be responsible for making payment to the Dentist for the difference between the Approved Amount and the Delta Dental Benefit. Because claims must be submitted to Delta Dental within twelve months of the date Dental Services are completed in order to be entitled to Benefits under this Policy, You should check Your Explanation of Benefits to be sure a Claim is submitted to Delta Dental for all Dental Services that You receive from Non-Participating Dentists within twelve months after all Dental Services are completed.

1.3 - Locating a Network Dentist
Delta Dental offers two easy ways to find a Network Dentist 24 hours a day, 7 days a week. You can either:
- Call 1-888-899-3734
- Access Our Website at www.deltadentalcoversme.com
By calling, You can get a customized list of Network Dentists, both Delta Dental PPO℠ Dentists and Delta Dental Participating Specialists within the area of Your request. Delta Dental mails the list to Your home. By searching on Our Website, You can get a customized list of Network Dentists in a specific town. The list can be downloaded right away. You can search for as many towns as needed. Using either method, You can get listings of general Dentists only or specialists only. You can get Network Dentist information for any of the 50 states should you need a Dentist when You travel outside of New Jersey.

1.4 - Selecting a Network Dentist

- All Delta Dental Participating Specialists and Delta Dental PPO℠ Dentists have agreed, in writing, with Our claims processing procedures. For example, Delta Dental Participating Specialists and Delta Dental PPO℠ Dentists agree not to bill separate charges for infection control measures.

- Delta Dental Participating Specialists and Delta Dental PPO℠ Dentists have agreed to accept the least of their actual charge, the fee they file with Delta Dental or Another Delta Dental Plan, or Delta Dental’s Approved Amount under the program as payment in full. They agree to not charge You for amounts more than shown in the “patient payment” part of the Explanation of Benefits.

- Delta Dental Participating Specialists and Delta Dental PPO℠ Dentists send Claims straight to Delta Dental on Your behalf. You may be asked to fill out part of the form during Your visit.

- Delta Dental Participating Specialists and Delta Dental PPO℠ Dentists will get the Benefit straight from Delta Dental. You will get an Explanation of Benefits. It will inform You of the amount You owe.

1.5 - Your First Dental Visit

Tell Your Dentist that You are covered under this Delta Dental Policy. Also, give the Dentist Your Delta Dental Subscriber ID number and your identification card. The Dentist should contact Delta Dental at 1-888-899-3734 or at www.deltadentalcoversme.com to check Your eligibility as well as details about this Policy, such as Covered Services, Deductibles, Benefit Limitations, Exclusions, and Dental Services that require Prior Authorization for Pediatric Enrollees covered under this Policy.

If Your Dentist plans to perform a Dental Service for a Pediatric Enrollee that requires Prior Authorization, You or Your Dentist must take the steps set out in Sections 10 and 12. Where Prior Authorization is required but not obtained, We can apply a penalty of up to 50% of the charges that would otherwise be covered.
If Your Dentist submits a proposed treatment plan to Delta Dental, Delta Dental will supply a Pre-Treatment Estimate for Services. A Pre-Treatment Estimate is available for Dental Services for adult Enrollees and also for Pediatric Enrollees even for Dental Services for which Prior Authorization is not required. This will let You and Your Dentist find out how much of the charge You owe. Before treatment is started, be sure You talk with Your Dentist about the total amount of his or her fee. Delta Dental suggests You ask Your Dentist to send a request for Pre-Treatment Estimate for treatment costing $300 or more even if Prior Authorization for required services rendered to Pediatric Enrollees is not required. Keep in mind that Pre-Treatment Estimates are only estimates and not promises or guarantees of payment.

1.6 - Contacting Delta Dental

On the Web

Visit us at www.deltadentalcoversme.com to sign up for our secure Web site. Once signed up, You can check Your Covered Services and eligibility. You can check claim payments, and view the Cost Share and Deductible balances for all of the people covered under Your Policy. You can also print more ID Cards for persons covered under Your Policy.

By Phone

Delta Dental Customer Service can be reached toll-free by calling 1-888-899-3734 Monday through Friday during business hours. Customer Service Representatives can help You with:

- Confirming eligibility for Benefits
- Helping You understand Your Policy
- Checking the status of a Claim
- Determining how much of Your Deductible or Cost Share Limit is left
- Locating a Network Dentist

Calls to Our toll-free number first go through Our Interactive Voice Response (IVR) system. The IVR includes claim payment information, a directory of Network Dentists, and contact information. You can also transfer to a Customer Service Representative. A touch-tone phone is needed to use the IVR. We also offer services for Covered Persons who are non-English speaking or hearing-impaired.

By Mail

Delta Dental of Wisconsin, Inc.
P.O. Box 103
Stevens Point, WI 54481-0828

(Policy service is provided by Delta Dental of Wisconsin, Inc.)
2.0 - POLICY DEFINITIONS

1. “Adult Enrollee” means a **Covered Person** who is age nineteen (19) or older at the Policy Anniversary Date.

2. “Adverse Benefit Determination” means a decision Delta Dental makes that results in a Benefit Amount which is less than the amount submitted on the **Claim** or request for Prior Authorization. This includes Delta Dental’s not paying any Benefit Amount for the Dental Service. Where Prior Authorization is required but not obtained, **We** can apply a penalty of up to 50% of the charges that would otherwise be covered.

3. “Allowed Amount” means the fee amount used in calculating the Benefit for the given Covered Service. The Benefit may be less than the Allowed Amount due to Benefit Limitations. The Allowed Amount may be less than the Approved Amount.

4. “Alternate Treatment Limitation” means the Benefit under this Policy is based on the least costly Covered Service Delta Dental determines is sufficient for the diagnosis or treatment of Your dental problem. Alternate Treatment Limitations only apply to Dental Services rendered to Adult Enrollees.

5. “Annual Period” means each **Calendar Year**.

6. "Another Delta Dental Plan" means a Delta Dental member company in a state other than New Jersey and/or a Delta Dental member company affiliate of such corporation.

7. “Approved Amount” means the total fee which the Delta Dental Participating Specialist, Delta Dental Participating Dentist, or Delta Dental PPO℠ Dentist has agreed to accept as payment in full for the Dental Service provided. It includes both Delta Dental’s Benefit Amount and the Your payment obligation. For Non-Participating Dentists it is the fee actually charged for the Dental Services provided.

8. “Benefit” or “Benefit Amount” is the dollar amount which Delta Dental will pay under this **Policy** toward a Covered Service.

9. “Benefit Limitations” are restrictions on the Benefit Amounts payable under this Policy. Benefit Limitations include the following: (a) the **Coverage Percent** specified in Section 7.0; (b) the Deductible amount and the Benefit Maximum specified in Section 6.0; (c) the limit on the Approved Amount for the Dental Service specified in Section 7.0; (d) the Alternate Treatment Limitation described in Section 6.5, and (e) the Specific Limitations contained in 7.0.

10. “Benefit Maximum” means the total dollar limit that Delta Dental will pay toward Covered Services for each Adult Enrollee during a Coverage Period. See Section 6.4.
11. “Benefited As” refers to when a Dental Service is performed or pre-estimated for an Adult Enrollee, but the Benefit Amount is based on a different Dental Service or category of Dental Service. When this happens, all the Benefit Limitations and Exclusions apply to the Dental Service for which Delta Dental pays the Benefit.

12. “Child with Special Health Care Needs” means a Pediatric Enrollee: (a) who has a chronic physical, developmental, behavioral, or emotional condition and who as a result requires Dental Service of a type or amount beyond that required by children generally and (b) for whom Delta Dental has received satisfactory proof of (a) above within twelve (12) months prior to the date the Dental Service was completed.

13. “Civil Union” is defined as a Civil Union under the New Jersey Civil Union Act (L. 2006, c. 103) or a same sex relationship validly established under the law of another state that gives substantially all of the rights and obligations of married couples.

14. “Civil Union Partner” means a person who is a party to a Civil Union.

15. “Claim” is a request to Delta Dental to pay a Benefit under this Policy.

16. “Coinsurance Percent” means the percentage of the Allowed Amount for a Covered Service paid by a Covered Person after any applicable Benefit Limitations.

17. “Completion Date” means the date that a Dental Service is finished. Most Dental Services are finished in one day. The Completion Date for multistage Dental Services is defined in Section 9.1 of this Policy.

18. “Comprehensive” means when a Dental Service is inclusive of a related Dental Service. For example: periodontal osseous surgery is the Comprehensive Dental Service as it includes not only a periodontal flap procedure but also flap entry and closure.

19. “Comprehensive Orthodontic Treatment” means a coordinated diagnosis and treatment leading to the improvement of a Patient’s craniofacial dysfunction and/or dentofacial deformity which may include anatomical, functional and/or esthetic relationships. Treatment may utilize fixed and/or removable orthodontic appliances and may also include functional and/or orthopedic appliances in growing and non-growing Patients. Comprehensive Orthodontic Treatment does not include minor treatment to control harmful habits limited or interceptive treatment unless such services are a significant part of a Comprehensive Orthodontic Treatment plan that meets the Medically Necessary Orthodontic Services criteria.

20. “Cost Share” means the total amount a Covered Person pays out of his or her own pocket per Calendar Year for Covered Services completed by Network Dentists on a Pediatric Enrollee during the Coverage Period.
21. “Cost Share Limit” means the maximum amount of Cost Share that a Covered Person must pay per Calendar Year before Delta Dental pays 100% of the Allowed Amount for Covered Services completed by Network Dentists on Pediatric Enrollees.

22. “Coverage Effective Date” means the date, beginning at 12:01 a.m., that the Covered Person becomes eligible for Benefits under this Policy.

23. “Coverage Expiration Date” means midnight on the date that all Covered Persons stop being eligible for the Benefits under this Policy.

24. “Coverage Percent” means the percentage of the Allowed Amount to be paid by Delta Dental for a Covered Service by a Network Dentist.

25. “Coverage Period” means the term of this Policy, in months, beginning on the Coverage Effective Date and ending on the Coverage Expiration Date, during which most covered Dental Services must be finished by the Completion Date as defined in Section 9.1 of this Policy to be eligible for a Benefit under this Policy.

26. “Covered Person” means the Subscriber and each other person who is eligible and enrolled for coverage under this Policy. A Covered Person may include the Subscriber’s Spouse, a former Spouse for whom the Subscriber is legally liable to provide dental coverage, a Civil Union or Domestic Partner, and each child who is either a Pediatric Enrollee or who is an Adult Enrollee who is age 19 but less than 27 years of age. A child shall include a biological child, stepchild, foster child, legally adopted child, child of the Subscriber’s Civil Union Partner or Domestic Partner, and children under a court appointed guardianship. A Covered Person must be listed on the application that is part of this Policy, be accepted by Delta Dental as being covered under this Policy, and on whose behalf the proper Subscription Charges have been paid. A person shall no longer be a Covered Person under this Policy at the point when such person stops meeting the definition of Subscriber and/or Covered Person, or as of the Coverage Expiration Date. Persons in military service are not eligible to be Covered Persons under this Policy.

27. “Covered Service(s)” are Dental Services that are listed under the heading “Covered Services” in Section 7.0. Covered Services completed by Network Dentists and Non-Network Dentists are eligible for payment of Benefits under this Policy subject to applicable Benefit Limitations and Exclusions.

28. “Deductible” means the specified dollar amount that a Covered Person is required to pay toward a Covered Service each Calendar Year before Delta Dental will pay any Benefit toward the Covered Service. That dollar amount is specified in Section 7.0 of this Policy.
29. “Definitive Procedure” means any Dental Service which has been given a Current Dental Terminology (CDT) procedure code. Definitive Procedures may be combined for payment purposes. That a Dental Service has been assigned a CDT procedure code does not mean it is a Covered Service.


31. “Delta Dental Participating Dentist” means a Dentist who (a) has a participation agreement in force with Delta Dental or with Another Delta Dental Plan but is not a Delta Dental Participating Specialist or a Delta Dental PPO℠ Dentist as defined in this Policy. Delta Dental Participating Dentists are not Network Dentists under this Policy and the Cost Share Limit for Pediatric Enrollees does not apply to the Dental Services they provide.

32. “Delta Dental Participating Specialist” means a Dentist who (a) has a participation agreement in force with Delta Dental; (b) holds a current specialty permit in the state where the Dentist performs Dentistry in periodontics, prosthodontics, endodontics, orthodontics, or oral surgery and limits his or her practice to the respective specialty, and (c) has registered with Delta Dental as a specialist. A Delta Dental Participating Specialist who has signed an agreement to accept PPO Approved Fees is a Delta Dental PPO℠ Dentist and is a Network Dentist for purposes of this Policy.

33. “Delta Dental PPO℠ Dentist” means a Dentist who has a Delta Dental PPO℠ Dentist agreement in force with Delta Dental or, in states other than New Jersey, is a Dentist identified by Another Delta Dental Plan as a Delta Dental PPO℠ Dentist.

34. “Dental Service(s)” means dental treatment and related procedures rendered by a Dentist or other person duly licensed to render that treatment by the state or country in which they were rendered.

35. “Dentally Necessary” or “Dental Necessity” means Dental Services that a Dentist, exercising prudent clinical judgment, would provide to a Patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) in accordance with generally accepted standards of dental practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for successfully treating the Patient's illness, injury or disease; and (3) not primarily for the convenience of the Patient, Dentist or other health care provider, and (4) not more costly than an alternative service or sequence of services fulfilling the requirements of the specific situation or the extenuating circumstances as to the diagnosis or treatment of that Patient's illness, injury or disease. For the purposes of this definition, "generally accepted standards of dental practice" means standards that are based on credible scientific evidence published in peer-reviewed dental literature generally recognized by the relevant dental community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.
36. “Dentist” means a person duly licensed to practice Dentistry in the state or country in which the treatment is rendered.

37. “Dentistry” is defined as the evaluation, diagnosis, prevention and/or treatment (non surgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body; provided by a Dentist, or another person duly licensed to render that treatment by the state or country in which they were rendered within the scope of his/her education, training and experience.

38. “Domestic Partner” means a person who is a party to a domestic partnership under the New Jersey Domestic Partnership Act, N.J.S.A. 26:8A-1 et. seq.

39. “Emergency Dental Services” means Covered Services performed on Pediatric Enrollees that are necessary for the immediate relief of a specific condition of the oral cavity and/or contiguous tissues which causes severe and/or intractable pain and/or could compromise the life, health, or safety of the beneficiary unless treated immediately. For example: pain or acute infection from a restorable or non-restorable tooth.

40. “Excluded” and “Exclusions” mean Dental Services and/or charges for which no Benefit is payable under this Policy. They may be Specific Exclusions (see Section 7.0) or General Exclusions (see Section 8.0).

41. “Explanation of Benefits” means a computer-generated statement from Delta Dental that You will receive after We process a Claim for You or a Covered Person describing how Delta Dental determined the Benefit for the Dental Services submitted on the Claim or telling You the information Delta Dental requires before a Benefit determination can be made.”

42. "Family” means the Subscriber, Spouse, and children who are all Covered Persons eligible for coverage and enrolled by the Subscriber.

43. “General Exclusion(s)” means the Exclusions listed in Section 8.0.

44. “In Conjunction With” means in close association with or as part of another Dental Service or episode of treatment including, but not limited to, being performed on the same day.

45. “Medically Necessary Orthodontic Services” means Comprehensive Orthodontic Treatment that meets the criteria for “Dental Necessity” as defined in this policy and also meets at least one of the following criteria: a. The Pediatric Enrollee’s condition necessitates a core of 26 or more points on a correctly scored modified Salzmann Malocclusion Severity Assessment; or
b. The Pediatric Enrollee demonstrates that the requested treatment will significantly ameliorate a mental, emotional, or behavioral condition associated with the Pediatric Enrollee’s dental condition; or
c. The Pediatric Enrollee presents evidence demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, or facial trauma resulting in severe functional difficulties.

Medically Necessary Orthodontic Services are a Covered Service for Pediatric Enrollees only and require Prior-Authorization. Where Prior Authorization is required but not obtained, We can apply a penalty of up to 50% of the charges that would otherwise be covered. Orthodontic Services are not covered for Adult Enrollees of any age and not covered for Covered Persons age 19 and above.

46. “Network Dentist” means a Delta Dental Participating Specialist and/or Delta Dental PPO℠ Dentist as defined in this Policy. The Cost Share Limit applies for services provided by a Network Dentist for Pediatric Enrollees.

47. “Non-Network Dentist” means any Dentist who is neither a Delta Dental Participating Specialist nor a Delta Dental PPO℠ Dentist. Delta Dental Participating Dentists and Non-Participating Dentists are Non-Network Dentists. The Cost Share Limit does not apply for services provided by a Non-Network Dentist for Pediatric Enrollees.

48. “Non-Participating Dentist” means any Dentist other than a “Delta Dental Participating Dentist,” “Delta Dental Participating Specialist,” or “Delta Dental PPO℠ Dentist” as defined in this Policy. Non-Participating Dentists are Dentist that do not have an agreement in place with Delta Dental. Non-Participating Dentists are not Network Dentists under this Policy and the Cost Share Limit for Pediatric Enrollees does not apply to the Dental Services they provide.

49. “Participating Dentist Maximum Approved Charge” or “PMAC” means the highest amount which Delta Dental approves for purposes of compensating the Delta Dental Participating Dentist for a Dental Service. This includes the amount payable by both Delta Dental and the Covered Person.

50. “Participating Specialist Maximum Approved Charge” or “PSMAC” is defined as the highest amount which Delta Dental approves for purposes of compensating the Delta Dental Participating Specialist for a Dental Service. This includes the amount payable by both Delta Dental and the Covered Person.

51. “Patient(s)” are people who receive the Dental Services, a Prior Authorization, or a Pre-Treatment Estimate for Dental Services.

52. “Pediatric Enrollee” means a Subscriber and each other person who is eligible and enrolled for coverage under this Policy who is less than age nineteen (19) at the Policy Anniversary Date. It includes the Subscriber’s Spouse, a former Spouse for whom the Subscriber is legally liable to
provide dental coverage, a Civil Union or Domestic Partner, a biological child, stepchild, foster child, legally adopted child, child of the Subscriber’s civil union or domestic partner, and children under a court appointed guardianship who are less than age nineteen (19) at the Policy Anniversary Date. The Pediatric Enrollee is the person who (a) is listed on the application that is a part of this Policy; (b) has been accepted by Delta Dental as a Pediatric Enrollee; and (c) for whom the proper Subscription Charges have been paid in full. A person shall no longer be a Pediatric Enrollee under this Policy at the point when such person is age 19 or over at the most recent Policy Anniversary Date, or otherwise stops meeting the definition of Pediatric Enrollee, or as of the Coverage Expiration Date. Persons in military services are not eligible to be Pediatric Enrollees under this Policy.

53. “Policy” means this document.

54. “Policy Anniversary Date” means the date this Policy becomes effective and the beginning of each 12 month period this Policy is subsequently renewed.

55. “PPO Approved Fee” means the fee approved by Delta Dental or by Another Delta Dental Plan for Dental Services rendered by Delta Dental PPO Dentists in the respective state. It can be changed from time to time by Delta Dental or by Another Delta Dental Plan.

56. “Premium Subsidy” means the payment of part or all of premium or Subscription Charges for this Policy per federal law.

57. “Pre-Treatment Estimate” is the result of a process where after a Dentist submits a treatment plan, Delta Dental notifies the Dentist and Subscriber of one or more of the following: (a) Patient’s eligibility; (b) Covered Services; (c) Benefit Amount; (d) Coinsurance Percent; (e) Deductibles; (f) Benefit Maximums; (g) Cost Share Limits; (h) Benefit Limitations; and (i) Exclusions.

58. “Prior Authorization” and “Prior Authorized” is a determination whether a service to be rendered to a Pediatric Enrollee (listed in Appendix A to Section 12) is a Covered Service by Delta Dental. Where Prior Authorization is required, the determination must take place prior to the Dental Service being performed or Benefits will be reduced by Delta Dental. It responds to a request for approval of Dental Services as Dentally Necessary or orthodontic services as Medically Necessary Orthodontic Services. Where Prior-Authorization is required but not obtained, We can apply a penalty of up to 50% of the charges that would otherwise be covered.

59. “Same Dentist” refers to the same individual Dentist. It also refers to the same dental office, group practice, or billing entity with which he/she practice(s).

60. “Schedule of Benefits” is a listing of the specific Covered Services and Benefit Limitations and Exclusions for Dental Services provided under this Policy. The Schedule of Benefits is contained in Section 7.0 of this Policy. General Exclusions are listed in Section 8.0.
61. “Specific Exclusions” mean the Specific Exclusions listed in Section 7.0 as applicable to the Dental Service.

62. “Specific Limitations” mean the Specific Limitations listed in Section 7.0 as applicable to the Dental Service.

63. “Spouse” means the Subscriber’s lawful Spouse, the Subscriber’s Civil Union Partner, or the Subscriber’s Domestic Partner.

64. “Subscriber” means a person: (a) who has filled out and signed the application needed for coverage under the Policy; (b) who has been accepted by Delta Dental for this Policy; (c) whose proper Subscription Charges are paid in full; and (d) whose coverage stays active. The Subscriber is also the person who enrolls his or her eligible Family for coverage.

65. “Subscription Charges” means the total monthly premium due for this Policy.

66. “Subscription Rate” is the category rate for coverage in effect for this Policy defined as follows:
   a. “Individual Only” means coverage is provided only for the Subscriber named in this Policy;
   b. “Couple” means coverage is provided for the Subscriber and the Subscriber’s Spouse.
   c. “Two Party” means coverage is provided for the Subscriber plus one child who is either a Pediatric Enrollee or one Adult Enrollee age 19 or over who is named in this Policy;
   d. “Three Party” means coverage is provided for the Subscriber and two other Covered Persons.
   e. “Four Party” means coverage is provided for the Subscriber and three or more other Covered Persons.
   f. “Couple Plus One” means coverage is provided for the Subscriber, Spouse, and one additional Covered Person.
   g. “Couple Plus Two” means coverage is provided for the Subscriber, Spouse, and two additional Covered Persons.
   h. “Coverage Plus Three or More” means coverage is provided for the Subscriber, Spouse, and three or more additional Covered Persons.

67. “We,” “Us,” and “Our” means Delta Dental of New Jersey, Inc.

68. “You” or “Your” means the Subscriber.
3.0 - ELIGIBILITY AND ENROLLMENT

Eligibility for This Policy
You are eligible for this Policy if You:

1. have filled in and signed the proper application;
2. have been accepted by Delta Dental for coverage;
3. have paid in full the Subscription Charges for all Covered Persons;
4. are 18 years of age or an emancipated minor; and
5. are a permanent, legal resident of New Jersey.

A permanent, legal resident is a person who lives in New Jersey for at least 6 months during the calendar year. Delta Dental may need proof of residency from You. Proof of residency may be in the form of a New Jersey state driver’s license or voter’s registration card. You can also provide a current month’s utility bill with Your home street address or other similar proof. You should tell Delta Dental if You move outside of New Jersey within thirty (30) days. We will end coverage effective as of the last day of the Coverage Period.

3.1 - Pediatric Enrollees
Pediatric Enrollees under age 19 are eligible for coverage under this Policy. To be eligible for this Policy, Pediatric Enrollees should:

1. be listed on the application that is part of this Policy;
2. have been accepted by Delta Dental for coverage;
3. have paid in full the Subscription Charges due;
4. be under age 19;
5. be You, Your Spouse, Your child, Your Spouse’s child, stepchild, foster child, or legally adopted child, or as required by a court order.

Eligibility for a Pediatric Enrollees, begins on the first day You become covered under Your Policy. New Pediatric Enrollees can be added under the Changing Coverage section below. Please refer to the Schedule of Covered Services for more information.

3.2 - Adult Enrollees
Your Spouse, Domestic Partner, Civil Union Partner, and Your children age 19 and over are eligible for coverage under this Policy as Adult Enrollees. To be eligible for this Policy, Adult Enrollees must:

1. be listed on the application that is part of this Policy;
2. have been accepted by Delta Dental for coverage;
3. have paid in full the Subscription Charges due; be age 19 but under age 27; or;
4. A disabled child of the Subscriber, Spouse, Domestic Partner or Civil Union Partner over the age of 26 who is not capable of self-sustaining employment. This must be due to a developmental disability or physical handicap. Your child must be dependent upon You or Your Spouse for total or partial support.
A doctor’s statement certifying a child as disabled must be submitted to Delta Dental within 31 days of Your child’s 27th birthday. After that, Delta Dental may need You to resubmit proof of Your child’s continuing eligibility. A disabled child is eligible for coverage until any one of the following events happens:

a) You do not give proof of the child’s continuing dependence as a result of disability or physical handicap;

b) You or Your Spouse are no longer covered under this Policy;

c) You do not keep paying Your Subscription Charges;

d) Delta Dental ends this Policy.

Delta Dental will accept a court order if the judge directs the Subscriber to cover dental care costs for a child below the age of 27.

Eligibility for an Adult Enrollees, begins on the first day You become covered under Your Policy. New Adult Enrollees can be added under the Changing Coverage section below. Please refer to the Schedule of Covered Services for more information.

3.3 - Continued Coverage for Other Family Members of the Subscriber

A Covered Person who is a Family member of the Subscriber may choose to keep his or her coverage under this Policy as a Subscriber with his or her own Policy if:

1. The Subscriber dies;

2. upon termination of the Covered Person’s marriage to or Civil Union or domestic partnership with the Subscriber; or

3. upon termination of the marriage, or the Civil Union or domestic partnership between the Covered Person’s parent or guardian and the Subscriber

Covered Persons must keep meeting all other eligibility rules. They must, as the new Subscriber, pay applicable Subscription Charges.

3.4 - Changing Coverage

You may only change coverage types (e.g., from Subscriber Only to Couple) at the Policy Anniversary Date or within thirty (30) days after any of the following “qualifying events”:

1. marriage (including entry into a Civil Union or domestic partnership);

2. divorce or legal separation (including termination of Civil Union or domestic partnership);

3. birth or adoption of a child;
4. death of a Covered Person;
5. a Covered Person’s loss of other dental coverage; or,
6. a court orders You to give dental coverage to a child, even if You are not the custodial parent.

Tell Delta Dental about any changes to Your eligibility status or the status of a child, such as the birth of a child within thirty (30) days. If You choose not to sign up a child during Your first enrollment or within thirty (30) days of a qualifying event, You must wait until the next Policy Anniversary Date.

For court-ordered coverage, submit an application to Delta Dental within thirty (30) days of the date of the order. Coverage will be effective on the date set by the court order. The Subscriber must pay the applicable Subscription Charges due.

To change a Subscription Rate type, submit a new application on paper or call Customer Service.

3.5 - The Coverage Period
The Coverage Period begins on the Coverage Effective Date shown in the Policy page attached to this Policy. The coverage ends on the last day of the month for which Subscription Charges were paid or this Policy was terminated by Delta Dental. If You fail to pay the Subscription Charges in full when due or during the grace period referred to in Section 4.3, Our subsequent acceptance of a payment from You for coverage prior to the Coverage Expiration Date shall reinstate Your coverage, but such reinstatement shall not provide coverage for the period between the end of the grace period through the date We accepted Your payment.

Eligibility for other Covered Family members of a Subscriber ends:

1. at the end of the month for a Spouse, when the Subscriber and Spouse divorce (unless coverage is provided subject to a court order);
2. at the end of the month for a Civil Union Partner or Domestic Partner, when the Civil Union or domestic partnership is terminated (unless coverage is provided subject to a court order);
3. when a child covered as an Adult Enrollee reaches his or her 27th birthday;
4. for disabled children, the last day of the year when the disabled child covered as an Adult Enrollee is no longer physically or mentally incapacitated as described in Section 3.2; or
5. for all Family members who are Covered Persons, the last day of the month when the Subscriber becomes deceased.
Fraudulent Information
If a Covered Person gives false or misleading information to defraud Delta Dental, this Policy becomes null and void. We shall tell the proper state and regulatory authorities. This includes, but is not limited to, the Office of the Insurance Fraud Prosecutor (OIFP). It is a crime to give false, incomplete, or misleading information on purpose to defraud Delta Dental. Penalties include imprisonment, fine, and denial of Benefits.

4.0 - SUBSCRIPTION CHARGES, POLICY RENEWAL, AND TERMINATION

4.1 - Initial and Policy Renewal
This Policy's first Coverage Period is twelve (12) months. Your Policy will renew automatically. If You choose not to renew, tell Us in writing within 30 days prior to the Policy Anniversary Date. Or, cancel Your Policy through Our Website at www.deltadentalcoversme.com. Subscription Charges may change once a year upon renewal. You will receive written notice of a Subscription Charges change. We will provide at least ninety (90) days before any such change takes effect for this Policy.

4.2 - Subscription Charges Due Date
You must pay the Subscription Charges by the Subscription Charges’ due date. Failure to pay the Subscription Charges in full when due will result in termination of this Policy for all Covered Persons. The first Subscription Charges are due before the Coverage Effective Date of this Policy. If paying by credit card, You may choose to pay future Subscription Charges monthly, semi-annually or once a year. Subsequent Subscription Charges are due on the first day of each month for the following month’s Subscription Charges. If paying by check, You must pay the Subscription Charges for the entire twelve month Coverage Period.

4.3 - Grace Period
If You are not getting a Premium Subsidy for this Policy, You have a grace period of thirty (30) days past the due date to pay the Subscription Charges. If You do not make payment, Delta Dental will end this Policy. Your Policy stays in force during the grace period. If You fail to pay the Subscription Charges during the grace period, Our subsequent acceptance of a payment from You for coverage prior to the Coverage Expiration Date shall reinstate Your coverage, but such reinstatement shall not provide coverage for the period between the end of the grace period through the date We accepted Your payment.

If You are getting a Premium Subsidy for this Policy, You have a grace period of ninety (90) days past the due date to pay Your Subscription Charges. If You do not make payment, Delta Dental will end this Policy. Your Policy stays in force during the grace period. We will pay Benefits under this Policy only for Dental Services completed during the first thirty (30) days of the grace period unless and until You have paid Us all the charges due through the date of payment.
4.4 - Non-Payment of Subscription Charges and Reinstatement
Your Policy ends if You have not paid the full amount of the Subscription Charges due by the end of the grace period. If this occurs, You cannot reapply for coverage for twenty-four (24) months from the date Your Policy ended. After 24 months, We will need a new application. The Effective Date of Your new coverage will be the date of Our approval.

4.5 - Subscription Charges Adjustments
Subscription Charges adjustments may happen during the Coverage Period if the following happens:

1. The number of Covered Persons under this Policy changes;

2. There is a change in law or rule that affects this Policy’s Benefits;

If You have pre-paid the Subscription Charges for a month in which a change in the Subscription Charges is scheduled to take effect, Delta Dental will include a retroactive change for the new amount in Your next month’s automatic charge from Your credit card account.

4.6 - Renewal, Amendment or Modification
Delta Dental reserves the right to change the terms of this Policy at the Policy Anniversary Date. This includes the Covered Services, Benefit Limitations and Exclusions, and the applicable Subscription Charges. We will give at least ninety (90) days written notice of such changes prior to the Policy Anniversary Date. Such changes shall be in effect for all Covered Persons under this Policy. They are not specific to any single Covered Person. You do not need to tell Delta Dental if You accept the change to the Policy. Your failure to terminate this Policy and Your payment of Subscription Charges shall be interpreted as acceptance of the change(s).

No change of the terms of this Policy shall be binding upon Delta Dental unless endorsed, in writing, and signed by an authorized officer of Delta Dental. Such endorsement shall be deemed a part of this Policy, effective from the endorsement. Any amendment or Policy change required by law or regulation shall become effective as of the effective date required by such law or regulation.

4.7 - Subscription Charges Refunds
Delta Dental will pay You back any Subscription Charge paid in advance for periods after the termination date of this Policy. Delta Dental has the right to end coverage for any persons found to be ineligible for this Policy and/or who have submitted Claims with false information on purpose. In the case of ineligible persons signed up for in this Policy, Delta Dental will pay back any Subscription Charges paid for ineligible persons. If Delta Dental has paid Claims for an ineligible person, the Subscriber, must pay back Delta Dental for the amount of all Claims paid. Delta Dental may reduce any refund for the amount of any known overpayment.
4.8 - Termination of this Policy

Termination by You

This Policy has a Coverage Period of twelve (12) months. You may end this Policy during the Coverage Period for You or for the Covered Persons under Your Policy’s. You may do so only for the following reasons:

For You
1. You become covered under a group dental plan offered by Your employer;
2. You die;
3. You enter military service;
4. Your marital status changes;
5. Your Civil Union status or domestic partnership status changes;
6. At the time of Your Policy renewal.

For Your covered Spouse, Civil Union or Domestic Partner
1. Your covered Spouse becomes covered under a group dental plan offered by an employer;
2. Your covered Spouse dies;
3. Your covered Spouse enters military service;
4. Your covered Spouse ceases to be Your covered Spouse as defined in this Policy;
5. At the time of Your Policy renewal.

For Your covered child (Pediatric Enrollees under age 19 and Adult Enrollees age 19 and over)
1. Your covered child becomes covered under a group dental plan offered by an employer;
2. Your covered child dies;
3. Your covered child enters military service;
4. Your covered child’s marital status changes;
5. At the time of Your Policy renewal.

You must tell Us within 30 days of the date of any of the above events happen. You must also give Us sufficient proof of the event. If You follow the notice and proof requirements of termination, We will pay back any unused Subscription Charges to You.

You may also terminate coverage for all children, Pediatric Enrollees under age 19 and Adult Enrollees age 19 and over by giving Us fourteen (14) days’ advance written notice, in which event We will revise Your rate type and pay back any unused Subscription Charges to You.

Termination by Delta Dental

We may terminate this Policy during the Coverage Period only for the following reasons:
1. You fail to pay Subscription Charges when due or within the grace period;
2. A Covered Person commits fraud or makes an intentional misrepresentation of a material fact, as determined by Us;
3. A Covered Person lets a person not covered under this Policy use the I.D. card of anyone covered under this Policy;
4. A Covered Person fails to follow the terms of this Policy as determined by Us.
We will give You notice of termination and the reason for termination. Except for numbers 1 and 2 above, We will give You notice at least thirty (30) days prior to the last date of coverage.

If Delta Dental terminates this Policy for any reason before any period for which Subscription Charges has been paid, We will pay back any unearned Subscription Charges to You.

4.9 - Payment of Benefits After Termination
A Claim for a Dental Service must be filed within twelve (12) months after the date the Dental Service was finished. A Covered Person will be responsible for payment of any Dental Services finished after termination of A Covered Person’s coverage because they are excluded (see Section 8.1 (2)(d), 8.1(oo), 8.2(2)(d), and 8.2 (jj)).

5.0 - CHOOSING A DENTIST

5.1 - Payment for Covered Services rendered to Covered Persons by Delta Dental PPO℠ Dentists to shall be as follows:

(a) Delta Dental’s Benefit Amount

(i) Delta Dental shall pay for each Covered Person receiving Covered Services completed by a Delta Dental PPO℠ Dentist the Coverage Percent specified in the Schedule of Benefits. (See Section 7.0);

(ii) The Coverage Percent shall be applied against the fee level set forth in (iii) for the Dental Service upon which the Benefit is based subject to and after application of the Benefit Limitations and Exclusions;

(iii) The fee level shall be the least of: (a) the Delta Dental PPO℠ Dentist’s fees for the Dental Services filed with Delta Dental or Another Delta Dental Plan; (b) the actual fee charged for the Dental Services; or (c) the PPO Approved Fee for the Dental Services.

(b) Covered Person’s Payment
The Delta Dental PPO℠ Dentist shall charge and collect from the Covered Person the difference between the Delta Dental Benefit Amount for the respective Dental Service (after application of Benefit Limitations and Exclusions) and the Approved Amount for the Dental Service performed.
(c) **Total Charge for Covered Service**

The **Delta Dental PPO℠ Dentist** shall accept as payment in full for each **Covered Service** Delta Dental’s **Benefit Amount** and the **Covered Person’s** payment as described above and shall make no additional charge for the **Covered Service**. The total charge will not exceed the lowest of: (a) the actual fee charged; (b) the **Delta Dental PPO℠ Dentist’s** fee as filed with Delta Dental or **Another Delta Dental Plan**; or (c) the **PPO Approved Fee** for the **Dental Service** performed.

The **Coverage Percent** for **Covered Services** rendered to **Pediatric Enrollees** by **Delta Dental PPO℠ Dentists** will be 100% once the **Cost Share Limit** has been met for that **Annual Period**.

**5.2 - Payment for Covered Services** rendered to **Covered Persons** by **Delta Dental Participating Specialists** shall be as follows:

(a) **Delta Dental’s Benefit Amount**

(i) **Delta Dental** shall pay for each **Covered Person** receiving **Covered Services** completed by a **Delta Dental Participating Specialist** the **Coverage Percent** specified in the **Schedule of Benefits**. (See Section 7.0.);

(ii) The **Coverage Percent** shall be applied against the fee level set forth in (iii) for the **Dental Service** upon which the **Benefit** is based subject to and after application of the **Benefit Limitations** and **Exclusions**;

(iii) The fee level shall be the least of: (a) the **Delta Dental Participating Specialist’s** fees for the **Dental Services** filed with Delta Dental; (b) the actual fee charged for the **Dental Services**; or (c) the **PSMAC** for the **Dental Service** upon which the **Benefit** is based.

(b) **Covered Person’s Payment**

The **Delta Dental Participating Specialist** shall charge and collect from the **Covered Person** the difference between the **Delta Dental Benefit Amount** for the respective **Dental Service** (after application of **Benefit Limitations** and **Exclusions**) and the **Approved Amount** for the **Dental Service** performed.

(c) **Total Charge for Covered Service**

The **Delta Dental Participating Specialist** shall accept as payment in full for each **Covered Service** Delta Dental’s **Benefit Amount** and the **Covered Person’s** payment as described above and shall make no additional charge for the **Covered Service**. The total charge will not exceed the lowest of: (a) the actual fee charged; (b) the **Dentist’s fee** as filed with Delta Dental; or (c) the **PSMAC** for the **Dental Service** performed.
The **Coverage Percent** for **Covered Services** rendered to **Pediatric Enrollees** by **Delta Dental Participating Specialists** will be 100% once the **Cost Share Limit** has been met for that **Annual Period**.

### 5.3 Payment for **Covered Services** rendered to **Covered Persons** by **Delta Dental Participating Dentists** shall be as follows (Pediatric Enrollee Cost Share Limit Does Not Apply):

(a) **Delta Dental’s Benefit Amount**

(i) **Delta Dental** shall pay for each **Covered Person** receiving **Covered Services** completed by a **Delta Dental Participating Dentist** the **Coverage Percent** specified in the **Schedule of Benefits**. (See Section 7.0);

(ii) The **Coverage Percent** shall be applied against the fee level set forth in (iii) for the **Dental Service** upon which the **Benefit** is based subject to and after application of the **Benefit Limitations** and **Exclusions**;

(iii) The fee level shall be the least of: (a) the **Delta Dental Participating Dentist’s** fees for the **Dental Services** filed with **Delta Dental** or **Another Delta Dental Plan**; (b) the actual fee charged for the **Dental Services**; or (c) PPO Approved Fee for the **Dental Services**.

(b) **Covered Person’s Payment**

The **Delta Dental Participating Dentist** shall charge and collect from the **Covered Person** the difference between the **Delta Dental Benefit Amount** for the respective **Dental Service** (after application of **Benefit Limitations** and **Exclusions**) and the **Approved Amount** for the **Dental Service** performed.

(c) **Total Charge for Covered Service**

The **Delta Dental Participating Dentist** shall accept as payment in full for each **Covered Service Delta Dental’s Benefit Amount** and the **Covered Person’s** payment as described above and shall make no additional charge for the **Covered Service**. The total charge will not exceed the lowest of: (a) the actual fee charged; (b) the **Dentist’s** fee as filed with **Delta Dental** or **Another Delta Dental Plan**; or (c) the **PMAC** for the **Dental Service** performed.

### 5.4 - Payment for **Covered Services** rendered to **Covered Persons** by **Non-Participating Dentists** shall be as follows (Pediatric Enrollee Cost Share Limit Does Not Apply):

(a) **Delta Dental’s Benefit Amount**

(i) **Delta Dental** shall pay for each **Covered Person** receiving **Covered Services** completed by a **Non-Participating Dentist** the **Coverage Percent** specified in the **Schedule of Benefits** (Section 7.0);
(ii) The **Coverage Percent** shall be applied against the fee level set forth in (iii) for the **Dental Service** upon which the **Benefit** is based subject to and after application of the **Benefit Limitations** and **Exclusions**;

(iii) The fee level shall be the lower of (a) the actual fee charged for the **Dental Service** or (b) the **PPO Approved Fee**.

(b) **Covered Person’s Payment**
   The **Non-Participating Dentist** shall charge and collect from the **Covered Person** the difference between the actual fee charged and the **Delta Dental Benefit Amount** for each **Dental Service**.

(c) **Total Charge for Covered Service**
   The **Non-Participating Dentist** will collect the entire fee he or she has charged for the **Dental Services** performed.

Be sure to inform Your Dentist that You are covered by this Policy and talk to Your Dentist about any charges You may owe before treatment begins.
Examples for Pediatric Enrollees

You can search for a Network Dentist on the Delta Dental Website. Select only Delta Dental PPO℠ in the Product Selection section (step 1). The chart below has an example of out-of-pocket costs for Dental Services provided by each type of Dentist. These examples are for illustration purposes only. The first example assumes no Cost Share Limit or Deductibles apply. The second example shows how they can affect the Benefit Amount.

### EXAMPLE FOR PEDIATRIC ENROLLEES

<table>
<thead>
<tr>
<th>Dentist Type &amp; Network</th>
<th>Network Dentists</th>
<th>Non-Network Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Example</strong>*</td>
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<td><strong>$800</strong></td>
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<td><strong>$800</strong></td>
</tr>
<tr>
<td><strong>Coverage Percent</strong></td>
<td><strong>60%</strong></td>
<td><strong>60%</strong></td>
</tr>
<tr>
<td><strong>Delta Dental Payment</strong></td>
<td><strong>$384</strong></td>
<td><strong>$480</strong></td>
</tr>
<tr>
<td><strong>Pediatric Enrollee’s Payment</strong></td>
<td><strong>$640 - $384 = $256</strong></td>
<td><strong>$800 - $480 = $320</strong></td>
</tr>
</tbody>
</table>

The following examples with 3 Dental Services show how Deductibles would affect the amount You must pay. **Note:** Your Deductible and Coverage Percent also apply to Emergency Dental Services.
The **Benefit** will be the amount (if any) **We** would have paid under this **Policy** if the **Dentist** were a **Delta Dental PPO℠ Dentist**.

<table>
<thead>
<tr>
<th>EXAMPLE #2</th>
<th>Delta Dental PPO℠ Dentist</th>
<th>Delta Dental Participating Specialists (New Jersey only)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dentist Charge for Dental Services</strong></td>
<td>1. $1,200</td>
<td>$1,200</td>
</tr>
<tr>
<td></td>
<td>2. $1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td></td>
<td>3. $800</td>
<td>$ 800</td>
</tr>
<tr>
<td><strong>Dentist Approved Amount for Dental Services</strong></td>
<td>1. $1,000</td>
<td>$1,100</td>
</tr>
<tr>
<td></td>
<td>2. $640</td>
<td>$ 800</td>
</tr>
<tr>
<td></td>
<td>3. $480</td>
<td>$ 600</td>
</tr>
<tr>
<td><strong>Allowed Amount less Deductible for Dental Service No. 1</strong></td>
<td>1. $1,000 - $75 = $925</td>
<td>$1,100 - $75 = $1,025</td>
</tr>
<tr>
<td><strong>Allowed Amount for Dental Services No. 2 and No. 3</strong></td>
<td>1. $640</td>
<td>$ 800</td>
</tr>
<tr>
<td></td>
<td>2. $480</td>
<td>$ 600</td>
</tr>
<tr>
<td><strong>Total Allowed Amount</strong></td>
<td>$2,045</td>
<td>$2,325</td>
</tr>
<tr>
<td><strong>Coverage Percent</strong></td>
<td>1. 60%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>2. 60%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>3. 60%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Delta Dental Benefit Amount Before Cost Share Limit Applied</strong></td>
<td>$1,227</td>
<td>$1,395</td>
</tr>
<tr>
<td><strong>Pediatric Enrollee’s Payment Before Cost Share Limit applied (Approved Total Amount Less Delta Dental Benefit Payment Amount)</strong></td>
<td>$2,120 - $1,227 = $893</td>
<td>$2,500 - $1,395 = $1,105</td>
</tr>
<tr>
<td><strong>Pediatric Enrollee’s Cost Share Limit</strong></td>
<td>$350</td>
<td>$350</td>
</tr>
<tr>
<td><strong>Delta Dental Benefit Payment Amount</strong></td>
<td>$1,770 ($2,120 approved less $350 Cost Share Limit)</td>
<td>$2,070 ($2,420 approved less $350 Cost Share Limit)</td>
</tr>
</tbody>
</table>
Examples for Adult Enrollees

You can search for a **Network Dentist** on the **Delta Dental** Website. Select only Delta Dental PPO℠ in the Product Selection section (step 1). The chart below has an example of out-of-pocket costs for **Dental Services** provided by each type of **Dentist**. These examples are for illustration purposes only. The first example assumes no **Deductibles** apply. The second example shows how it can affect the **Benefit Amount**.

### EXAMPLE FOR ADULT ENROLLEES

<table>
<thead>
<tr>
<th>Dentist Type &amp; Network</th>
<th>Network Dentists</th>
<th>Non-Network Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Delta Dental PPO℠ Dentist (Delta Dental PPO℠ network)</td>
<td>Delta Dental Participating Specialists (New Jersey only)</td>
</tr>
</tbody>
</table>

You will be responsible for the difference between Delta Dental’s Benefit Amount and the least of the Delta Dental PPO℠ Dentist’s actual fee, the fee the Dentist has filed with Us or Another Delta Dental Plan, or the PPO Approved Fee for the Dental Service performed.

You will be responsible for the difference between Delta Dental’s Benefit Amount and the least of the Dentist’s actual fee, the fee filed with Delta Dental, or the Delta Dental Participating Specialist’s Maximum Approved Charge for the Dental Service performed.

You will be responsible for the difference between Delta Dental’s Benefit Amount and the Dentist’s actual fee for the service performed. Delta Dental’s Benefit Amount is based on the lesser of the Dentist’s actual fee, the fee filed with Delta Dental, or the PPO Approved Fee.

### Example*

<table>
<thead>
<tr>
<th>Dentist Charge for Dental Services</th>
<th>Delta Dental PPO℠ Dentist</th>
<th>Delta Dental Participating Specialists (New Jersey only)</th>
<th>Non-Network Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Approved Amount for Dental Services</th>
<th>$640</th>
<th>$800</th>
<th>$1,000</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Allowed Amount for Dental Services</th>
<th>$640</th>
<th>$800</th>
<th>$700</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Coverage Percent</th>
<th>60%</th>
<th>60%</th>
<th>60%</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Delta Dental Payment</th>
<th>$384</th>
<th>$480</th>
<th>$420</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Adult Enrollee’s Payment</th>
<th>$640 - $384 = $256</th>
<th>$800 - $480 = $320</th>
<th>$1,000 - $420 = $580</th>
</tr>
</thead>
</table>
The following examples with 3 Dental Services show how Deductibles and Benefit Maximums would affect the amount You must pay.

<table>
<thead>
<tr>
<th>EXAMPLE FOR ADULT ENROLLEES</th>
<th>Delta Dental PPO℠ Dentist</th>
<th>Delta Dental Participating Specialists</th>
<th>Non-Participating Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist Charge for Dental Services</td>
<td>1. $1,200</td>
<td>$1,200</td>
<td>$1,200</td>
</tr>
<tr>
<td></td>
<td>2. $1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td></td>
<td>3. $800</td>
<td>$800</td>
<td>$800</td>
</tr>
<tr>
<td>Dentist Approved Amount for Dental Services</td>
<td>1. $1,000</td>
<td>$1,100</td>
<td>$1,200</td>
</tr>
<tr>
<td></td>
<td>2. $640</td>
<td>$800</td>
<td>$800</td>
</tr>
<tr>
<td></td>
<td>3. $480</td>
<td>$600</td>
<td>$600</td>
</tr>
<tr>
<td>Allowed Amount less Deductible for Dental Service No. 1</td>
<td>1. $1,000 - $50 = $950</td>
<td>$1,100 - $50 = $1,050</td>
<td>$800 - $50 = $750</td>
</tr>
<tr>
<td>Allowed Amount for Dental Services No. 2 and No. 3</td>
<td>1. $640</td>
<td>$800</td>
<td>$800</td>
</tr>
<tr>
<td></td>
<td>2. $480</td>
<td>$600</td>
<td>$600</td>
</tr>
<tr>
<td>Total Allowed Amount</td>
<td>$2,070</td>
<td>$2,450</td>
<td>$2,150</td>
</tr>
<tr>
<td>Coverage Percent</td>
<td>1. 60%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>2. 60%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>3. 60%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Delta Dental Benefit Amount Before Benefit Maximum</td>
<td>$1,242</td>
<td>$1,470</td>
<td>$1,290</td>
</tr>
<tr>
<td>Delta Dental Benefit Payment Amount Due to Benefit Maximum</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Adult Enrollee’s Payment (Approved Total Amount Less Delta Dental Benefit Payment Amount)</td>
<td>$2,070 - $1,000 = $1,070</td>
<td>$2,450 - $1,000 = $1,450</td>
<td>$3,000 - $1,000 = $2,000</td>
</tr>
</tbody>
</table>
6.0 - POLICY COVERAGE TERMS

The following sections outline the Policy Terms and the Schedule of Benefits. These sections will give You information about Deductibles, Cost Share Limit for Pediatric Enrollees, Benefit Maximums for Adult Enrollees, Coverage Percentage, and the Benefit Limitations and Exclusions.

6.1 - Deductibles
The annual Deductible for Covered Services is: (a) $135 for each Pediatric Enrollee; (b) $405 for all Pediatric Enrollees; (c) $75 for each Adult Enrollee; (d) $225 for all Adult Enrollees when services are rendered by a Network Dentist; and (e) $100 for each Adult Enrollee; (d) $300 for all Adult Enrollees when services are rendered by a non-Network Dentist; Once a Covered Person has paid the annual Deductible, no additional Deductible is required to be paid for Covered Services during that year.

6.2 – Cost Share Limit (Applicable only to Pediatric Enrollees)
The annual Cost Share Limit is $350 per Pediatric Enrollee and a total of $700 for all Pediatric Enrollees covered by this Policy. Once the annual Cost Share Limit is reached, We pay 100% of the Allowed Amount of any Covered Services completed by their Network Dentist (Delta Dental PPOSM Dentists and Delta Dental Participating Specialists) during the year. The Cost Share Limit does not apply for Covered Services completed by Non-Network Dentists.

6.3 - Coverage Percent and Coinsurance Percent

6.3.1 - The Coverage Percent for each Covered Service is listed in Section 7.0 of this Policy. By way of illustration, this Policy computes Benefits by applying the Coverage Percent to the Allowed Amount for the Covered Service. If the Coverage Percent shown is “60,” Delta Dental will pay 60% of the Allowed Amount for the Covered Service, after any applicable Deductible. The amount that the Covered Person must pay is the difference between the Benefit paid for the Dental Service and the Approved Amount for the Dental Service.

6.3.2 - The Coinsurance Percent for each Covered Service is based on the Coverage Percent listed in Section 7.0 of this Policy. It is the percentage of the Allowed Amount for a Covered Service paid by a Covered Person after any applicable Benefit Limitations. By way of illustration, if the Coverage Percent is 60%, We will pay 60% of the Allowed Amount for the Covered Service (after application of any Deductible) and the Coinsurance Percent is 40%.

6.4 - Benefit Limitations and Exclusions
This Policy does not cover every aspect of dental care and every Dental Service recommended or performed by a Dentist. This Policy provides payment only toward Covered Services. Covered Services are subject to Benefit Limitations and Exclusions listed in Section 7.0 and 8.0. When Section 7.0 states that “no Benefit will be paid for a Dental Service,” the Covered Person is responsible for paying the Dentist the full Approved Amount for that Dental Service.
6.5 - Alternate Treatment Limitations (Applicable to Adult Enrollees)

A more costly Dental Service may be selected by the Covered Person and his or her Dentist than the one that Delta Dental decides is sufficient for the diagnosis or treatment of a condition. This does not mean that the Covered Person or Dentist’s choice of treatment is wrong or insufficient. However, Benefits under this Policy for Covered Adults are based on the least costly Covered Service that Delta Dental decides is sufficient for the diagnosis or treatment of a dental problem. If the Dental Service performed is a more costly treatment, the Covered Person is financially responsible for the difference between Delta Dental’s Benefit Amount and the Approved Amount for the actual Dental Service performed.

Where a Covered Person chooses Dental Services more expensive than Delta Dental determines to be sufficient treatment, he or she is responsible for that part of the Dentist’s Approved fee not paid by Delta Dental. Delta Dental’s payment is the same no matter which Dental Service is chosen. This means the Covered Person may have higher out-of-pocket costs if he or she selects a Dental Service that costs more.

6.6 - Benefit Maximums (Applicable to Adult Enrollees)

The maximum Calendar Year Benefit payment for each Adult Enrollee is $1,000 for Dental Services rendered by a Network Dentist and $750 for Dental Services rendered by an Out-of-Network Dentist.

7.0 - SCHEDULE OF BENEFITS

This Policy pays Benefits for and only for Covered Services listed in the following schedules subject to Benefit Limitations as set forth in this Section 7.0. The schedules show for each Covered Service whether a Deductible applies to the Covered Service and the Coverage Percent for the Covered Service. No Benefits are payable for any Dental Services described in any of the Specific Exclusions in Section 7.0 or the General Exclusions set forth in Section 8.0.

Please refer to Sections 5.0 and 6.3 of this Policy for a description of the Coverage Percent and an explanation of the amount that a Covered Person will owe for any Dental Service for which Delta Dental pays a Benefit.

7.1 - DENTAL SERVICES RENDERED TO PEDIATRIC ENROLLEES

<table>
<thead>
<tr>
<th>7.1 Diagnostic</th>
<th>Necessary Dental Services to assist the Dentist in evaluating the existing oral condition to determine required dental treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>Coverage Percent Paid by Delta Dental</td>
</tr>
<tr>
<td>7.1.1 Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Dental evaluations including comprehensive, periodic, oral evaluation for Pediatric Enrollees under the age of three and counseling with the primary caregiver, limited oral evaluations that are problem focused and detailed oral evaluations that are problem focused, and second opinions. Comprehensive oral evaluation includes evaluation of hard and soft tissues of the oral cavity, diagnosis, oral cancer evaluation, and screening, charting of all abnormalities, and treatment planning.</td>
</tr>
</tbody>
</table>
### 7.1 Diagnostic

Necessary **Dental Services** to assist the **Dentist** in evaluating the existing oral condition to determine required dental treatment.

#### Specific Limitations

A) **No Benefit** will be paid for dental evaluations of any type when any mix of these **Dental Services** is performed by the **Same Dentist**: (a) more than once (1) in a 6-month period, and (b) more than once (1) in a 3-month period for a **Child with Special Health Care Needs** (requires **Prior Authorization**). No allowance will be paid for more than one (1) **Comprehensive** evaluation, including an oral evaluation for a **Pediatric Enrollee** less than three years of age, performed by the **Same Dentist** within one (1) year.

B) **No Benefit** will be paid for separate charges for evaluation of hard and soft tissues of the oral cavity, diagnosis, oral cancer evaluation and screening, charting of all abnormalities, and treatment planning when performed **In Conjunction With** an oral evaluation.

#### Covered Services

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.2 Yes</td>
<td>100%</td>
<td>Intraoral complete mouth series (CMX) and panoramic x-rays</td>
</tr>
</tbody>
</table>

#### Specific Limitations

A) **No Benefit** will be paid for intraoral complete series and panoramic x-rays with or without bitewings when any mix of these **Dental Services** is performed more than once within 3 years.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.3 Yes</td>
<td>100%</td>
<td>Intraoral radiographs (periapicals)</td>
</tr>
</tbody>
</table>

#### Specific Limitations

A) **No Benefit** will be paid for intraoral radiographs taken as routine working, final treatment, and follow up radiographs by the **Same Dentist** for endodontic treatment.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.4 Yes</td>
<td>100%</td>
<td>Bitewing x-rays</td>
</tr>
</tbody>
</table>

#### Covered Services

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.5 Yes</td>
<td>100%</td>
<td>Cephalometric radiographic images, intraoral and extraoral radiographic images, oral/facial photographic images, maxillofacial MRI, ultrasound, cone beam image capture, tests and examinations, viral culture, collection and preparation of saliva sample for laboratory diagnostic testing, sialography, sialoendoscopy.</td>
</tr>
</tbody>
</table>

#### Specific Limitations

None.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.6 Yes</td>
<td>100%</td>
<td>Pulp vitality test diagnostic casts for diagnostic purposes only and not in conjunction with other services</td>
</tr>
</tbody>
</table>

#### Specific Limitations

A) **No Benefit** will be paid for diagnostic casts in conjunction with non-diagnostic services.
## 7.1 Diagnostic

Necessary **Dental Services** to assist the **Dentist** in evaluating the existing oral condition to determine required dental treatment.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.7 Yes</td>
<td>100%</td>
<td>Oral pathology laboratory – accession/collection of tissue, examination-gross and microscopic, preparation and transmission of written report, accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report, other oral pathology procedures by report.</td>
</tr>
</tbody>
</table>

**Specific Limitations**

None.

### Diagnostic Services

#### Specific Exclusions

7.1.8 The following **Specific Exclusions** apply to diagnostic services.

**Specific Exclusions**

A) Any diagnostic service not listed as a **Covered Service** is **Excluded**. The following are also specifically **Excluded**: Pre-diagnostic cancer screening tests

## 7.2 Preventive Services

Necessary **Dental Services** to prevent future dental disease.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2.1 Yes</td>
<td>100%</td>
<td>Prophylaxis (teeth cleaning)</td>
</tr>
</tbody>
</table>

**Specific Limitations**

A) **No Benefit** will be paid for prophylaxis when: (a) any combination of prophylaxes is performed by the same dentist/dental office more than once (1) in a 6-month period, (b) more than once (1) in 3-month period for a **Child with Special Health Care Needs**.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2.2 Yes</td>
<td>100%</td>
<td>Office applied topical fluoride applications including fluoride varnish (per visit)</td>
</tr>
</tbody>
</table>

**Specific Limitations**

A) **No Benefit** will be paid for topical fluoride treatment by the same dentist/dental office: (a) more than once (1) per 6-month period, (b) when not performed in conjunction with a prophylaxis, or (c) more than once (1) every 3-month period for a **Child with Special Health Care Needs**.

B) **No Benefit** will be paid for fluoride varnish (a) more than once (1) per 3-month period for **Pediatric Enrollees** under six (6) years of age.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2.3 Yes</td>
<td>100%</td>
<td>Application of sealants</td>
</tr>
</tbody>
</table>

**Specific Limitations**

A) **No Benefit** will be paid for sealants when applied to any tooth surface other than the occlusal surface of premolars and permanent molars which are free of restorations (including sealants, preventive resin restorations placed on the occlusal surface of the same tooth on the same day).
### 7.2 Preventive Services

Necessary **Dental Services** to prevent future dental disease.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2.4 Yes</td>
<td>100%</td>
<td>Space maintainers to maintain space for eruption of permanent tooth/teeth (includes placement and removal), fixed unilateral and bilateral, removable bilateral only, recementation of fixed space maintainer, removal of space maintainer (for provider that did not place the appliance).</td>
</tr>
</tbody>
</table>

**Specific Limitations**
- **A)** No **Benefit** will be paid for space maintainers for missing permanent teeth.
- **B)** No **Benefit** will be paid for unilateral removable space maintainer.

### Preventive Services Specific Exclusions

7.2.5 The following **Specific Exclusions** apply to preventive services.

**Specific Exclusions**
- **A)** Any preventive service not listed as a **Covered Service** is **Excluded**. The following are also specifically **Excluded**:
  1. Procedures such as nutritional and tobacco counseling, oral hygiene instructions, risk assessment, and counseling.
  2. Fluoride gels, rinses, tablets, or other preparations meant for home application.
  3. Removal of space maintainers by the **Same Dentist** who placed the appliance.
  4. Procedures mainly for plaque control.
  5. Preventive resin restorations.

### 7.3 Basic Restorative Services

**Dental Services** for the restoration of teeth due to dental caries (decay) or fracture primarily using silver amalgam or composite resin materials as fillings after the decay is removed.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
</table>
| 7.3.1 Yes  | 50%                                  | • Amalgam (silver) fillings  
                       • Composite (tooth colored) fillings  
                       • Protective restoration/sedative filling  
                       • Pin retention |

**Specific Limitations**
- **A)** Restorations include all adjunctive services such as but not limited to local anesthesia, direct or indirect pulp caps, bases, liners, polishing, and adjusting occlusion. No separate benefit will be paid for these and/or similar adjunctive services.
- **B)** No **Benefit** will be made for more than one procedure code per tooth on the same day except when amalgam and composite restorations are placed on the same tooth.
- **C)** Reimbursement for occlusal restorations includes any extensions onto the occlusal one-third of the buccal or lingual surface(s) of the tooth.
- **D)** Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. An additional surface will be reimbursable only when the buccal (facial) or lingual margin extends beyond the proximal one-third of the buccal (facial) and/or lingual surface(s).
7.3 Basic Restorative Services

Dental Services for the restoration of teeth due to dental caries (decay) or fracture primarily using silver amalgam or composite resin materials as fillings after the decay is removed.

E) The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.

Basic Restorative Services
Specific Exclusions

7.3.2 The following Specific Exclusions apply to all basic restorative services.

Specific Exclusions
A) Any restorative procedure not specifically listed as a Covered Service is Excluded. The following are also specifically Excluded:
   1. Any procedures, restorations, or appliances associated with periodontal splinting, except for intra and extra-coronal provisional splinting due to dental trauma
   2. Resin infiltration
   3. Reattachment of tooth fragment
   4. Interim restorations

7.4 Restorative – Crowns, Gold Foils, Inlays, and Onlays

Dental Services directly or indirectly fabricated involving the specified material.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.4.1</td>
<td>Yes</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gold foils, indirectly fabricated single crowns to restore form and function, metallic inlays, onlays, indirectly fabricated (custom fabricated/cast) and prefabricated post and core, additional fabricated (custom fabricated/cast) and prefabricated post, and core build-up (including pins), additional procedures to construct new crown under existing partial denture framework, coping.</td>
</tr>
</tbody>
</table>

Specific Limitations
A) Gold foils, inlays, onlays, and crowns include all adjunctive services such as but not limited to local anesthesia, temporary crown placement, insertion with recementation, polishing, impressions, laboratory fees, adjusting occlusion, etc. No separate Benefit will be paid for these and/or similar adjunctive services.

B) No Benefit will be paid for gold foil restorations, inlay and onlay restorations unless they are performed in a teaching institution or residency program. No Benefit will be paid for non-metallic inlays and onlays.

C) No Benefit will be paid for indirectly fabricated crowns and onlays: (a) unless the teeth cannot be restored with other restorative materials, (b) when performed for cosmetic reasons, (c) for teeth that are not in occlusion or function, and (d) for teeth that have a poor long term prognosis.

D) No Benefit will be paid for gold foils and inlays: (a) when performed for cosmetic reasons, (b) for teeth that are not in occlusion or function, and (c) for teeth that have a poor long term prognosis.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.4.2</td>
<td>Yes</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prefabricated stainless steel, stainless steel crown with resin window, and resin crowns.</td>
</tr>
</tbody>
</table>

Specific Limitations
A) Prefabricated stainless steel and resin crowns include all adjunctive services such as but not limited to local anesthesia, insertion with cementation and adjusting occlusion. No separate Benefit will be paid for these and/or similar adjunctive services.
7.4 Restorative – Crowns, Gold Foils, Inlays, and Onlays

Dental Services directly or indirectly fabricated involving the specified material.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.4.3 Yes</td>
<td>50%</td>
<td>Crown repairs and recementation of crowns, inlays, onlays, post and cores, post removal, temporary crown (fractured tooth).</td>
</tr>
</tbody>
</table>

Specific Limitations

A) No Benefits will be paid for temporary crowns unless the tooth is fractured and the crown is placed as an immediate protective device.

7.4.4 The following Specific Exclusions apply to restorative – crowns, gold foils, inlays, and onlays:

Specific Exclusions

A) Any restorative procedure not specifically listed as a Covered Service. The following are also specifically Excluded:

1. Provisional or temporary or interim crowns (except for immediate protection of a fractured tooth)
2. Any procedures, restorations, or appliances associated with periodontal splinting
3. Restorative foundation for indirect restoration
4. Labial veneers

B) No Benefit will be paid for indirectly fabricated crowns, gold foils, inlays, and onlays: (a) when performed for cosmetic reasons or (b) unless the teeth cannot be restored to form and function with other restorative materials.

C) Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.

7.5 Endodontics

Necessary Dental Services for pulpal therapy and root canal therapy to treat or remove the nerves inside the tooth chamber and roots.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.5.1 Yes</td>
<td>50%</td>
<td>Root canal therapy, pulpal therapy for anterior and posterior primary teeth.</td>
</tr>
</tbody>
</table>

Specific Limitations

None.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.5.2 Yes</td>
<td>50%</td>
<td>Pulpotomy and pulpal debridement for primary and permanent teeth, partial pulpotomy for apexogenesis, treatment for root canal obstruction, incomplete therapy (inoperable, unrestorable, or fractured tooth), internal root repair of perforation.</td>
</tr>
</tbody>
</table>

Specific Limitations

None.
### 7.5 Endodontics

Necessary Dental Services for pulpal therapy and root canal therapy to treat or remove the nerves inside the tooth chamber and roots.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.5.3 Yes</td>
<td>50%</td>
<td>Apexification/recalcification (initial, interim, and final visits), apicoectomy/periradicular surgery, retrograde fillings, and pulpal regeneration, root amputation, hemisections.</td>
</tr>
</tbody>
</table>

**Specific Limitations**

None.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.5.4 Yes</td>
<td>50%</td>
<td>Retreatment of root canal therapy, post removal, canal preparation and fitting of preformed dowel or post, surgical procedure for isolation of tooth with rubber dam.</td>
</tr>
</tbody>
</table>

**Specific Limitations**

None.

---

### Endodontics

**Specific Exclusions**

7.5.5 The following Specific Exclusions apply to endodontic services:

**Specific Exclusions**

A) Any endodontic service not listed as a Covered Service. The following are specifically Excluded:

1. Pulp caps
2. Endodontic endosseous implant
3. Intentional reimplantation
4. Temporary restorations and routine postoperative care
5. Periradicular surgery without apicoectomy
6. Bone grafts and regenerative procedures in conjunction with periradicular surgery

B) No Benefit will be paid for endodontic treatment when performed on teeth: (a) not in occlusion, (b) not periodontally sound, (c) not with a good long-term prognosis; or (d) not needed for function.

C) Endodontic services, other than Emergency Dental Services, require Prior Authorization. Where Prior Authorization is required but not obtained, We can apply a penalty of up to 50% of the charges that would otherwise be covered.

D) Endodontic treatment includes all adjunctive services such as but not limited to local anesthesia; canal preparation/medication, routine working, final and follow up radiographs; and follow up care. No separate Benefit will be paid for these and/or similar adjunctive services.

---

### 7.6 Periodontics

Necessary procedures to treat diseases of the tissues (gums) and bone supporting the teeth.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.6.1 Yes</td>
<td>50%</td>
<td>Periodontal scaling and root planing, localized delivery of antimicrobial agents.</td>
</tr>
</tbody>
</table>

**Specific Limitations**

A) No Benefit will be paid for periodontal scaling and root planing within a 6-month period except for Children with Special Health Care Needs.
7.6 Periodontics

Necessary procedures to treat diseases of the tissues (gums) and bone supporting the teeth.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
</table>
| 7.6.2 Yes  | 50%                                  | • Periodontal maintenance  
                                     |  
                                     | • Full mouth debridement            |

Specific Limitations

None.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.6.3 Yes</td>
<td>50%</td>
<td>Surgical services, gingivectomy and gingivoplasty, gingival flap including root planing, apically positioned flap, clinical crown lengthening, osseous surgery, bone replacement graft first site and additional sites, biologic materials to aid in soft and osseous tissue regeneration, guided tissue regeneration, surgical revision, pedicle and free soft tissue grafts, subepithelial connective tissue graft, distal or proximal wedge, soft tissue allograft, combined connective tissue and double pedicle graft.</td>
</tr>
</tbody>
</table>

Specific Limitations

None.

7.6.4 The following *Specific Exclusions* apply to periodontic services:

**Specific Exclusions**

A) Any periodontal procedure not specifically listed as a *Covered Service*. The following are also specifically *Excluded*:

1. Anatomical crown exposure, provisional splinting,
2. Unscheduled dressing change
3. Laser disinfection and laser assisted new attachment procedures
4. Gingival irrigation
5. Provisional splinting

B) Periodontal treatment requires *Prior Authorization*. Where *Prior Authorization* is required but not obtained, *We* can apply a penalty of up to 50% of the charges that would otherwise be covered.

7.7 Prosthodontics – Fixed and Removable

*Dental Services* to replace missing permanent teeth (not including third molars) to address masticatory deficiencies (impaired chewing function).

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.7.1 Yes</td>
<td>50%</td>
<td>Removable maxillary and mandibular, complete and immediate complete dentures, resin and cast frame partial dentures (including any conventional clasps, rests, and teeth) to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s), and cuspid(s)), precision attachments, flexible base partial dentures (including any clasps, rests, and teeth), complete and partial overdentures.</td>
</tr>
</tbody>
</table>
7.7 Prosthodontics – Fixed and Removable

**Dental Services** to replace missing permanent teeth (not including third molars) to address masticatory deficiencies (impaired chewing function).

### Specific Limitations

A) **No Benefit** will be paid for removable complete and partial dentures: (a) more than once in a seven and a half (7.5) year period from the date of prior insertion even if Delta Dental did not cover the patient and/or pay a Benefit toward the prior Dental Service, or (b) if the existing denture is satisfactory or can be made satisfactory, or (c) unless the dentures become obsolete due to additional extractions or damaged beyond repair.

B) **No Benefit** will be paid for removable complete and partial dentures unless all needed dental treatment is completed prior to fabrication.

C) **No Benefit** will be paid for removable partial dentures for posterior teeth unless masticatory deficiencies exist due to fewer than eight posterior teeth (nature or prosthetic) in balanced occlusion.

### Deductible Coverage Percent Paid By Delta Dental

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.7.2 Yes</td>
<td>50%</td>
<td>Fixed partial dentures (bridges), including retainers (crowns) pontics, core buildups, and post and cores.</td>
</tr>
</tbody>
</table>

### Specific Limitations

A) **No Benefit** will be paid for fixed partial dentures (bridges), including retainers (crowns) pontics if the existing fixed partial denture is satisfactory or can be made satisfactory.

B) **No Benefit** will be paid for anterior fixed bridges unless the tooth/teeth being replaced are (a) unilateral, (b) adequate space exists, (c) the fixed bridges are for a **Child with Special Health Care Needs** that result in the inability to tolerate a removable denture, (d) the abutment teeth are periodontally sound and have a good long-term prognosis, and (e) considerations for single crowns are met.

C) **No Benefit** will be paid for posterior fixed bridges unless: (a) the tooth/teeth being replaced are unilateral, (b) there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth, (c) the fixed bridges are for a **Child with Special Health Care Needs** that result in the inability to tolerate a removable denture, (d) the abutment teeth are periodontally sound and have a good long-term prognosis, and (e) considerations for single crowns are met.

D) **No Benefit** will be paid for replacement of a fixed bridge unless all criteria are met.

**No Benefit** will be paid for a pediatric partial denture unless necessary to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth. A pediatric partial denture necessary to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth requires **Prior Authorization**. Where **Prior Authorization** is required but not obtained, **We** can apply a penalty of up to 50% of the charges that would otherwise be covered.

### Deductible Coverage Percent Paid By Delta Dental

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.7.3 Yes</td>
<td>50%</td>
<td>Adjustments, repairs, relines, rebases to removable complete and partial dentures.</td>
</tr>
</tbody>
</table>

### Specific Limitations

A) **No Benefit** will be paid for adjustments to removable complete and partial dentures on the same day or within 6 months after the insertion of the denture.

B) **No Benefit** will be paid for denture relines or rebases on the same day or within 12 months after denture insertion.
### 7.7 Prosthodontics – Fixed and Removable

**Dental Services** to replace missing permanent teeth (not including third molars) to address masticatory deficiencies (impaired chewing function).

C) No **Benefit** will be paid for adjustments on the same day or within 6 months after a reline, rebase, or repair.

D) A rebase or reline when performed more than once (1) per 12 months requires **Prior Authorization**. Where **Prior Authorization** is required but not obtained, **We** can apply a penalty of up to 50% of the charges that would otherwise be covered.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.7.4 Yes</td>
<td>50%</td>
<td>Recementation of fixed partial dentures (bridges).</td>
</tr>
</tbody>
</table>

**Specific Limitations**

None.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.7.5 Yes</td>
<td>50%</td>
<td>Repair of fixed partial dentures (bridges).</td>
</tr>
</tbody>
</table>

**Specific Limitations**

None.

### Prosthodontics – Fixed and Removable

#### Specific Exclusions

7.7.6 The following **Specific Exclusions** apply to fixed and removable prosthodontic services:

**Specific Exclusions**

A) Any fixed or removable prosthodontic procedures not listed as **Covered Services** are **Excluded**. The following are also specifically **Excluded**:

1. Interim complete, partial dentures, and prefabricated dentures
2. Any procedures; restorations; or appliances and/or crown and fixed partial denture associated with periodontal splinting
3. Interim, provisional, or temporary pontics and retainers, connector bars, stress breakers
4. Unilateral removable partial dentures or dentures without clasps
5. Tissue conditioning
6. Non-metallic inlays and onlays
7. Replacement of all teeth and acrylic on cast metal framework for removable partial dentures
8. Inlay and onlay fixed partial denture retainers unless performed in a teaching institution or residency program

B) Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.

### 7.8 Maxillofacial Prosthetics

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.8.1 Yes</td>
<td>50%</td>
<td>Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech and palatal augmentation, palatal lift prosthesis – initial, interim and replacement, obturator prosthesis, surgical, definitive and modifications, mandibular resection prosthesis with and without guide flange, feeding aid, surgical stents, radiation carrier, fluoride gel carrier, commissure splint, surgical splint, topical</td>
</tr>
</tbody>
</table>
### 7.8 Maxillofacial Prosthetics

| Medication carrier, adjustments, modification and repair to a maxillofacial prosthesis, maintenance and cleaning of maxillofacial prosthesis. |

**Specific Limitations**

A) **No Benefit** will be paid for adjustments to maxillofacial prosthetics within six months following placement.

B) Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.

### 7.9 Implants

A device designed to be inserted into the jaw bone to replace a missing tooth.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.9.1</td>
<td>Yes</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Implant body, abutment, and crown.</td>
</tr>
</tbody>
</table>

**Specific Limitations**

None.

#### Implants

**Specific Exclusions**

7.9.2 The following **Specific Exclusions** apply to implant services:

**Specific Exclusions**

A) Any implant services not listed as a **Covered Service** is **Excluded**. The following are also specifically **Excluded**:

1. Radiographic/surgical implant index, interim, temporary, or provisional procedures, eposteal and transosteal implants, debridement, bone grafts, connecting bar, implant maintenance procedures, implant repair, removal and recementation, implant/abutment supported fixed dentures, implant/abutment supported removable partial dentures, mini implants.
2. No Benefit will be paid for implant services unless the facial defects and/or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
3. Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.

### 7.10 Oral and Maxillofacial Surgical Services

Dental Services including the extraction of teeth, as well as minor surgical preparation of the mouth for insertion of dentures.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.10.1</td>
<td>Yes</td>
<td>50%</td>
</tr>
</tbody>
</table>

- Extraction of coronal remnants-deciduous tooth, extraction, erupted tooth or exposed root, surgical removal of erupted tooth or residual root, removal of soft tissue impactions
- Surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, placement of a device to aid eruption, surgical repositioning of teeth, transeptal/fiberotomy-supra crestal fiberotomy, surgical placement of anchorage device with or without flap.

**Specific Limitations**

A) **No Benefit** will be paid for local anesthesia and suturing (if needed) when performed by the **Same Dentist** on the same day as oral and maxillofacial surgery.
7.10 Oral and Maxillofacial Surgical Services

Dental Services including the extraction of teeth, as well as minor surgical preparation of the mouth for insertion of dentures.

B) No Benefit will be paid for routine postoperative care when performed by the Same Dentist who performed the surgery.

C) Surgical removal of erupted teeth or removal of impacted teeth or removal of residual roots (cutting procedure) require Prior Authorization. Where Prior Authorization is required but not obtained, We can apply a penalty of up to 50% of the charges that would otherwise be covered.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
</table>
| 7.10.2 Yes | 50%                                  | • Alveoloplasty in conjunction or not in conjunction with extractions  
|            |                                       | • Removal of lateral exostosis, torus palatinus or torus mandibularis, surgical reduction of osseous tuberosity; osseous tuberosity reduction, frenulectomy, frenuloplasty, excision of hyperplastic tissue and pericoronal gingiva  
|            |                                       | • Vestibuloplasty |

Specific Limitations

A) No Benefit will be paid for any service that has not been performed by a person duly licensed as an oral surgeon or as a Dentist in the state in which the treatment was rendered or by their auxiliary personnel who are duly licensed to perform the services at their direction.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.10.3 Yes</td>
<td>50%</td>
<td>• Oroantral fistula closure, primary closure of a sinus perforation and sinus repair, harvest of bone for use in grafting, resections of maxilla or mandible, (includes placement or removal of appliance and/or hardware to the same provider), surgical incision and drainage of abscess intraoral and extraoral, removal of a foreign body, partial ostectomy/sequestrectomy, maxillary sinusotomy, surgical and other repairs, skin and bone graft and synthetic graft, collection and application of autologous blood concentrate, osteoplasty, osteotomy, LeFort I, II, or III without bone graft, graft of the mandible or maxilla, autogenous or nonautogenous, sinus augmentations, repair of maxillofacial hard and soft tissue defects, sialolithomy, sialodochoplasty, excision of salivary gland and closure of salivary fistula, emergency tracheotomy, coronoidectomy, implant-mandibular augmentation purposes, appliance removal by report for provider that did not place appliance, splint or hardware.</td>
</tr>
</tbody>
</table>

Specific Exclusions

A) Any oral surgery service that is not listed as a Covered Service is Excluded.

Oral Surgery

Specific Exclusions

7.10.4 The following Specific Exclusions apply to Oral Surgery services:

Specific Exclusions

A) Any oral surgery service that is not listed as a Covered Service is Excluded.
### Oral Surgery

#### Specific Exclusions

B) No **Benefit** will be paid for any service that has not been performed by a person duly licensed as an oral surgeon or as a **Dentist** in the state in which the treatment was rendered or by their auxiliary personnel who are duly licensed to perform the services at their direction.

### 7.11 Medically Necessary Orthodontic Services

Services to prevent, intercept, or correct malocclusion (bad bite).

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.11.1 Yes</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• All listed services must meet <strong>Medically Necessary Orthodontic Services</strong> criteria</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Limited treatment for the primary, transitional and adult dentition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Interceptive treatment for the primary and transitional dentition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Minor treatment to control harmful habits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Comprehensive treatment for handicapping malocclusions of the permanent dentition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Orthodontics associated with orthognatic surgical cases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Repairs for orthodontic appliances</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Replacement of lost or broken retainers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Rebonding or recementing of brackets and/or bands</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Continuation of transfer cases or cases started outside the program</td>
</tr>
</tbody>
</table>

#### Specific Limitations

7.11.2 No **Benefits** will be paid for orthodontic services unless they meet the following criteria:

A) They are **Medically Necessary Orthodontic Services** as defined in Section 2.0.

B) **Medically Necessary Orthodontic Services** require **Prior Authorization**. Where **Prior Authorization** is required but not obtained, **We** can apply a penalty of up to 50% of the charges that would otherwise be covered.

C) Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

1. Orthodontic treatment requires **Prior Authorization** and is not considered for cosmetic purposes.
2. Orthodontic consultation can be provided once annually as needed by the same provider.
3. Pre-orthodontic treatment visit for completion of HLD (NJ-Mod2) assessment form (accessible at www.deltadentalnj.com), diagnostic photographs, diagnostic models, cephalometric radiograph and tracing, description of proposed treatment plan and patient’s diagnostic condition, and panoramic radiograph/views are required for consideration of services.
4. Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
5. Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
6. Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
7. The placement of the appliance represents the treatment start date.
### 7.11 Medically Necessary Orthodontic Services

Services to prevent, intercept, or correct malocclusion (bad bite).

- **8.** Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for a Dentist that did not start case and requires Prior Authorization.
- **9.** Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

D) Comprehensive treatment for handicapping malocclusions of the permanent dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form (accessible at www.deltadentalnj.com) with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.

E) Request for treatment must include diagnostic materials to demonstrate need, the form (accessible at www.deltadentalnj.com) and documentation that all needed dental preventive and treatment services have been completed.

F) Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

<table>
<thead>
<tr>
<th>Other Dental Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7.12 Adjunctive General Services</strong></td>
</tr>
</tbody>
</table>

**Covered Services**

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Palliative treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.12.1 Yes</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>

**Specific Limitations**

A) **No Benefit** will be paid for Palliative treatment: (a) not related to emergency treatment of dental pain, or (b) more than once (1) per date of service.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Anesthesia – local anesthesia NOT in conjunction with operative or surgical procedures, regional block, trigeminal division block, deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires hospitalization or general anesthesia-2 hour maximum time, intravenous conscious sedation/analgesia-2 hour maximum time, nitrous oxide/analgesia, non-intravenous conscious sedation-to include oral medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.12.2 Yes</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>

**Specific Limitations**

A) **No Benefit** will be paid for deep sedation/general anesthesia: (a) not performed by a Dentist; (b) for a medical condition not covered by the Policy; or (c) for a medical condition that does not require hospitalization or deep sedation/general anesthesia.

B) **No Benefit** will be paid for either deep sedation/general anesthesia or intravenous conscious sedation/analgesia that exceeds two (2) hours.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Behavior management</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.12.3 Yes</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>
7.12 Adjunctive General Services

Other Dental Services.

Specific Limitations

A) Behavior management is a Covered Service only if it: (a) is additional time to provide services for Children with Special Health Care Needs that requires more time than generally required to provide a dental service; (b) is accompanied by a request that indicates a specific medical diagnosis and clinical appearance.

B) Behavior management for additional time to provide services for Children with Special Health Care Needs that requires more time than generally required to provide a dental service and that is accompanied by a request that indicates a specific medical diagnosis and clinical appearance and exceeds the thresholds in (C) based on place of service requires Prior Authorization. Where Prior Authorization is required but not obtained, We can apply a penalty of up to 50% of the charges that would otherwise be covered.

C) One unit equals 15 minutes of additional time:
   - Office or clinic – 2 units
   - Inpatient/outpatient hospital – 4 units
   - Skilled nursing/long term care – 2 units

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.12.4 Yes</td>
<td>50%</td>
<td>Consultations by specialist or non-primary care Dentists</td>
</tr>
</tbody>
</table>

Specific Limitations

None.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.12.5 Yes</td>
<td>50%</td>
<td>Professional visits – house or facility visit-for a single visit to a facility regardless of the number of members seen on that day, hospital or ambulatory surgical center call-for cases that are treated in a facility, for cases taken to the operating room-dental services are provided for Pediatric Enrollees with a medical condition covered by this Policy which requires this admission as in-patient or out-patient (Prior Authorization is required), general anesthesia and outpatient facility charges for dental services are covered, dental services rendered in these settings by a dentist not on staff are considered separately, office visit for observation (during regular hours)-no other service performed.</td>
</tr>
</tbody>
</table>

Specific Limitations

A) No Benefit will be paid for more than one (1) house or facility visit regardless of the number of Pediatric Enrollees seen that day.

B) No Benefit will be paid for hospital or ambulatory surgical call for cases that are not treated in such a facility.

C) Professional visits – house or facility visit-for a single visit to a facility regardless of the number of members seen on that day, hospital or ambulatory surgical center call-for cases that are treated in a facility, for cases taken to the operating room-dental services are provided for Pediatric Enrollees with a medical condition covered by this Policy which requires this admission as in-patient or out-patient require Prior Authorization. Where Prior Authorization is required but not obtained, We can apply a penalty of up to 50% of the charges that would otherwise be covered.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.12.6 Yes</td>
<td>50%</td>
<td>Drugs – therapeutic parenteral drug (single administration, two or more administrations-not to be combined with single administration),</td>
</tr>
</tbody>
</table>
### 7.12 Adjunctive General Services

**Other Dental Services.**

- other drugs and/or medicaments by report

#### Specific Limitations

**A)** None.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
</table>
| 7.12.7 Yes | 50% | • Application of desensitizing medicament - per visit  
• Occlusal guard - for treatment of bruxism, clenching or grinding  
• Athletic mouthguard covered once per year  
• Occlusal adjustment  
  - Limited - (per visit)  
  - Complete  
• Odontoplasty  
• Internal bleaching |

#### Specific Limitations

**A)** No **Benefit** will be paid for complete occlusal adjustment more than once (1) per lifetime regardless of the number of visits.

**B)** No **Benefit** will be paid for an occlusal guard not performed to treat bruxism, clenching, or grinding.

**C)** No **Benefit** will be paid for more than one athletic mouthguard per 12 month period.

#### Adjunctive General Services

**Specific Exclusions**

7.12.8 The following **Specific Exclusions** apply to adjunctive general services:

**Specific Exclusions**

**A)** Any adjunctive **Service** not listed as a **Covered Service** is **Excluded**. The following are also specifically **Excluded**:

1. Fixed partial denture sectioning
2. Miscellaneous: reline and adjustment of occlusal guard, occlusal analysis including mounted case, enamel microabrasion, external bleaching  
   
   Case presentation, office visit after regularly scheduled hours, application of desensitizing resin

#### 7.2– DENTAL SERVICES RENDERED TO ADULT ENROLLEES

### 7.2 Diagnostic and Preventive Services

**Necessary Dental Services** to assist the **Dentist** in evaluating the existing oral condition to determine required dental treatment and **Dental Services** intended to prevent future dental disease.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid by Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2.1 No</td>
<td>100%</td>
<td>Dental evaluations, including comprehensive, routine and emergency evaluations, as well as consultations</td>
</tr>
</tbody>
</table>

#### Specific Limitations

**No Benefit** will be paid for dental evaluations of any type as well as consultations when any mix of these **Dental Services** is performed more than twice (2) in a 12-month period. No allowance will be paid for **Comprehensive** evaluations, performed by the **Same Dentist** within 3 years. Evaluations within 3 years after a **Comprehensive**
### 7.2 Diagnostic and Preventive Services

Necessary Dental Services to assist the Dentist in evaluating the existing oral condition to determine required dental treatment and Dental Services intended to prevent future dental disease.

Evaluation by the Same Dentist will be Benefited As periodic evaluations.

A Comprehensive periodontal evaluation is Benefited As a periodic evaluation when performed by the Same Dentist on the same date as periodontal maintenance.

No Benefit will be paid for separate charges for evaluation of hard and soft tissues of the oral cavity, periodontal charting, oral cancer evaluation and screening, blood pressure screenings, pulse, temperature, respiration, base EKG, treatment planning, evaluation of Patient’s dental and medical history, general and/or oral health assessments, diagnosis, pulp test (except limited oral evaluations-problem focused) when performed In Conjunction With an oral evaluation, consultation or other professional visit.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2.2 No</td>
<td>100%</td>
<td>Intraoral complete mouth series (CMX) and panoramic x-rays</td>
</tr>
</tbody>
</table>

**Specific Limitations**

No Benefit will be paid for intraoral complete series and panoramic x-rays with or without bitewings when any mix of these Dental Services is performed more than once within 5 years. No Benefit will be paid for a subset of x-rays that are part of the full-mouth series, such as bitewings.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2.3 No</td>
<td>100%</td>
<td>Intraoral radiographs</td>
</tr>
</tbody>
</table>

**Specific Limitations**

No Benefit will be paid for intraoral radiographs taken as routine working, final treatment, and follow up radiographs by the Same Dentist for endodontic treatment.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2.4 No</td>
<td>100%</td>
<td>Bitewing x-rays (one set equals one or more bitewing films taken on the same day)</td>
</tr>
</tbody>
</table>

**Specific Limitations**

No Benefit will be paid for bitewing x-rays in excess of two (2) sets in a 24 month period. A complete mouth series (CMX) or equivalent counts as one (1) set of bitewings in a 24 month period.

If the fee for vertical bitewings is the same or exceeds the fee for a CMX, the Benefit Amount for the vertical bitewings will be limited to the Benefit that would be payable for a complete mouth series. All Benefit Limitations for a CMX will apply.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2.5 No</td>
<td>100%</td>
<td>Pulp vitality test</td>
</tr>
</tbody>
</table>

**Specific Limitations**

No Benefit will be paid for pulp vitality tests when (a) performed by the Same Dentist with any other Dental Service on the same day, except when the only Dental Services performed by the Same Dentist on the same day are limited oral evaluation-problem focused, radiographs, or palliative treatment, or (b) when performed for any reason other than for the diagnosis of emergency conditions. No Benefit will be paid for more than one (1) pulp vitality test per visit.
7.2 Diagnostic and Preventive Services

Necessary **Dental Services** to assist the **Dentist** in evaluating the existing oral condition to determine required dental treatment and **Dental Services** intended to prevent future dental disease.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2.6 No</td>
<td>100%</td>
<td>Prophylaxis (teeth cleaning)</td>
</tr>
</tbody>
</table>

**Specific Limitations**

No **Benefit** will be paid for prophylaxis when (a) any combination of prophylaxes and periodontal maintenance is performed more than twice (2) in a 12 month period, (b) the prophylaxis is performed on the same day as periodontal maintenance by the **Same Dentist**, (c) the prophylaxis is performed by the **Same Dentist** during the time span beginning 14 days before and ending 90 days after a scaling and root planing or other periodontal treatment.

### Diagnostic and Preventive Services

**Specific Exclusions & Alternate Treatment Limitations**

The following **Specific Exclusions** and **Alternate Treatment Limitations** apply to diagnostic and preventive services.

**Specific Exclusions**

Any diagnostic or preventive service not listed as a **Covered Service** is **Excluded**. The following are also specifically excluded:

- Images such as cephalometric films, oral facial photographs, lateral skull and facial survey, cone beam capture and imaging & interpretation, maxillofacial ultrasound, maxillofacial MRI, sialography, sialoendoscopy.
- Tests such as bacteriologic tests, collection of microorganisms for culture and sensitivity, saliva tests, viral cultures, genetic tests, tests for susceptibility to caries (decay) and other oral diseases, pre-diagnostic cancer screening tests, medical tests and screenings, caries risk assessments.
- Oral pathology laboratory procedures.
- Diagnostic casts.
- Procedures such as nutritional and tobacco counseling, oral hygiene instructions, risk assessment, and counseling.
- Topical fluoride treatments (office procedure)
- Sealants
- Preventive resin restorations
- Space maintainers
- Temporomandibular joint diagnostic procedures
- Duplication of radiographs
- Fluoride gels, rinses, tablets, or other preparations meant for home application.
- A prophylaxis paste containing fluoride or a fluoride rinse or swish.
- Repair and removal of space maintainers.
- Procedures mainly for plaque control.
- Screening and assessments of patients

Any combination of individually listed periapical, occlusal, or bitewing radiographs on the same date of service by the **Same Dentist** are **Benefited As** a complete series if the **Approved Amount** for individual radiographs equals or exceeds the **Approved Amount** for a complete series. The **Delta Dental Benefit** for the individual radiographs will not exceed the **Benefit** it would pay for a complete mouth series or radiographs.

**Alternate Treatment Limitations**

The **Benefit Amount** for full mouth debridement will be determined based on the **Benefit Amount** for prophylaxis subject to the above **Specific Limitations** and **Specific Exclusions** applicable to prophylaxis. The **Adult Enrollee** is responsible for the difference between the **Benefit Amount** for the prophylaxis and the **Approved Amount** for the
Diagnostic and Preventive Services
Specific Exclusions & Alternate Treatment Limitations

Dental Service actually rendered.

Panoramic x-ray with or without bitewing x-rays performed on the same day is Benefited As a complete mouth series of x-rays and subject to the 5-year Frequency Limit. Eight or more periapical x-rays performed on the same day by the Same Dentist are Benefited As a full mouth series of x-rays and subject to the 5-year Frequency Limit.

7.3 Basic Restorative Services

Dental Services for the restoration of teeth solely due to dental caries (decay) or fracture primarily using silver amalgam or composite resin materials as fillings after the decay is removed.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Coverage Percent Paid By Delta Dental</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.3.1 Yes</td>
<td>60%</td>
<td>Amalgam (silver) fillings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Composite (tooth colored) fillings - anterior teeth only</td>
</tr>
</tbody>
</table>

Specific Limitations

No Benefit will be paid for amalgam (silver) fillings or composite (tooth colored fillings: (a) more than once (1) per surface of the same tooth per 24-month period, or (b) when performed on the same day or within 12 months following a post and core on the same tooth unless necessary due to caries, as a crown repair for a fracture, or access opening for root canal treatment.

Basic Restorative Services
Specific Exclusions & Alternate Treatment Limitations

The following Specific Exclusions and Alternate Treatment Limitations apply to all basic restorative services.

Specific Exclusions

Any restorative procedure not specifically listed as a Covered Service. The following are also specifically Excluded:
- Multiple pins in the same tooth
- Any procedures, restorations, or appliances associated with periodontal splinting
- Any restorative procedure not due to decay or fracture
- Protective restorations
- Resin infiltration
- Reattachment of tooth fragment
- Interim restorations
- Restorations and prefabricated porcelain crowns for primary teeth

Any restoration involving two or more contiguous surfaces is Benefited As one multiple surface restoration.

Restorations include all adjunctive services such as, but not limited to, local anesthesia, direct or indirect pulp caps, bases, liners, polishing, and adjusting occlusion. No separate Benefit will be paid for these and/or similar adjunctive services.

Alternate Treatment Limitations

Benefits will be paid for composite restorations only when placed in front teeth and first premolars. Benefits for posterior teeth other than first premolars will be based on amalgam restorations. The Benefit for composite restorations will be determined based on the Benefit Amount for amalgam restorations subject to the above Specific Limitations and Specific Exclusions applicable to amalgam restorations. The Adult Enrollee is responsible for the difference between the Benefit Amount for the amalgam restorations and the Approved Amount for the Dental Service actually rendered.
8.0 - GENERAL EXCLUSIONS (APPLICABLE TO ALL DENTAL SERVICES)
The reference to a Dental Service in this section does not mean that it would otherwise be a Covered Service.

8.1 - GENERAL EXCLUSIONS APPLICABLE TO PEDIATRIC ENROLLEES

1. A Pediatric Enrollee may transfer from the care of one Dentist to that of another Dentist and more than one Dentist may render the same Dental Services to the Pediatric Enrollee. In that case Delta Dental shall not be liable for more than the Benefit Amount it would pay if only one Dentist rendered all these Dental Services. Nor shall Delta Dental be liable for duplication of Dental Services.

2. The following are NOT due any Benefits and Delta Dental shall NOT make any payment under this Policy for or toward:
   a. Dental Services not specifically listed as Covered Services in Section 7.0 of this Policy, including but not limited to maxillofacial prosthetics.
   b. Dental Services that are not Dentally Necessary.
   c. Dental Services for which a Claim was not submitted within twelve (12) months after the date when the Dental Service was finished.
   d. Duplicative Dental Services performed on the same day.
   e. Dental Services provided by or in institutions owned or operated by the federal government such as Veterans Administration facilities.
   f. Dental Services rendered outside of the United States and its territories.
   g. Dental Services for injuries or conditions which are compensable under Workmen’s Compensation or Employers Liability laws; temporary disability laws or similar and whether or not the Pediatric Enrollee claims or receives benefits thereunder; Dental Services which are provided by any Federal or State or Provincial government agency, or are provided without cost to the Pediatric Enrollee by any municipality, county, or political subdivision or community agency, except to the extent such payments are not enough to pay the Approved Amount therefor.
   h. Dental Services performed or items supplied for any conditions, disease, sickness, or injury occurring while the Pediatric Enrollee is on active duty during military service, or for Dental Services or items provided under the laws of the United States of America or of any state of the United States or any foreign country or of any political subdivision of any of the foregoing.
i. A subset of a more Comprehensive Service (or a lesser Dental Service considered included in the Comprehensive Service).

j. Dental Services relating to more than the normal complement of teeth except for necessary oral surgery.

k. Any euphoric drugs or prescription drugs not specifically listed as Covered Services for Pediatric Enrollees.

l. Dental Services of a trial, experimental or investigational nature.

m. Charges for hospitalization.

n. Lab tests and/or lab exams and/or medical tests, etc. unless specifically listed as oral pathology lab tests that are Covered Services for Pediatric Enrollees.

o. Specialized techniques including but not limited to swing locks, dolder bars, special staining, halder bars, connector bars, metal bases, cone beam capture, imaging, interpretation and manipulation, ridge augmentation and/or preservation.

p. Dental Services submitted for payment as part of a Claim which has knowingly inaccurate information pertinent to the Claim (such as the Dental Service actually rendered, the date of service, the existence of other coverage, or the fee for the Dental Service).

q. Any Dental Service or item which is decided by Delta Dental not to be Dentally Necessary, appropriate, or meeting generally accepted standards of care, and/or lacking a reasonable prognosis for the treatment of the Pediatric Enrollee’s condition, disease or injury. Delta Dental reserves the right to check the Pediatric Enrollee’s dental records; this includes but is not limited to necessary radiographs; oral facial images; models, and financial records to decide whether a Dental Service or item meets these criteria.

r. Tooth preparation; acid etching; temporary restorations and crowns; bases; direct and indirect pulp caps; polishing; caries removal; microabrasion; endodontic working, final treatment, and follow up radiographs; gingivectomy In Conjunction With restorations; impressions; lab fees and material; local anesthesia services in conjunction with operative or surgical procedures, and other Dental Services which Delta Dental considers to be part of a more Comprehensive Dental Service.

s. Broken appointments.

t. Completion of Claims; copying of radiographs; providing documentation whether or not requested by Delta Dental; and requests for Prior Authorization or Pre-Treatment Estimate.
u. Periodontal charting.

v. Infection control, sterile surgical setup, OSHA compliance, and other facility charges.

w. Treatment rendered by persons other than Dentists. This does not apply to any Dental Services which may be performed according to law by a duly licensed dental hygienist or dental auxiliary if the treatment is performed under the supervision and guidance of the licensed Dentist; in accordance with all applicable governmental rules and the licensed Dentist submits the Claims for such treatment in accordance with all applicable governmental rules. If performed under these circumstances, the Benefit Amount for the Dental Services is determined as if the Dental Services had been rendered by a Dentist.

x. Dental Services or supplies that are cosmetic in nature. These Dental Services include but are not limited to charges for personalized or characterization of dentures.

y. Replacement of a lost, missing or stolen prosthetic or other appliance.

z. Onlays, crowns, veneers, prosthetic retainers, and pontics post and cores, and core buildups are limited to one per tooth without regard to whether the tooth has been sectioned.

aa. Home rinses and gels, toothbrushes, dental floss, personal hygiene items, other preparations and items for home use.

bb. Dental Services or supplies for which no charge is made that the Pediatric Enrollee is legally required to pay or for which no charge would be made if the Pediatric Enrollee did not have dental coverage.

cc. Dental Services for which the Dentist does not normally charge.

dd. Dental Services performed by the Dentist for immediate family members of the Dentist such as mother, father, Spouse, children, brother, sister, or for a Pediatric Enrollee in the Dentist’s household.

ee. Any duplicate prosthetic device or any other duplicate appliance.

ff. Myofunctional therapy.

gg. Dental Services to correct developmental or congenital malformations, replace or repair teeth due to such conditions.

hh. Dental Services or appliances for cosmetic purposes.
ii. **Dental Services** to diagnose or treat jaw joint disorders, such as, but not limited to, myofascial pain syndrome and temporomandibular joint disorders.

jj. Occlusal equilibration, occlusal analysis, and mounted case analysis.

kk. **Dental Services** or supplies due to an accidental injury.

ll. Fees which are incurred for any injury or disease arising out of the ownership, maintenance or use of a motor vehicle, except when such charges are excluded from coverage under any automobile insurance policy or program required or provided by statute covering such **Pediatric Enrollee**, where such exclusion is due to either an optional choice of a medical cost, deductible or an optional designation of the plan as the primary coverage.

mm. **Dental Services** which have not been completed during the **Coverage Period** except as expressly exempted by Section 9.0.

nn. Sales Taxes on **Dental Services**.

### 8.2 - GENERAL EXCLUSIONS APPLICABLE TO ADULT ENROLLEES

1. **An Adult Enrollee** may transfer from the care of one **Dentist** to that of another **Dentist** and more than one **Dentist** may render the same **Dental Services** to the **Adult Enrollee**. In that case **Delta Dental** shall not be liable for more than the **Benefit Amount** it would pay if only one **Dentist** rendered all these **Dental Services**. Nor shall **Delta Dental** be liable for duplication of **Dental Services**.

2. The following are NOT due any **Benefits** and **Delta Dental** shall NOT make any payment under this **Policy** for or toward:

   a. **Dental Services** not specifically listed as **Covered Services** in Section 7.0 of this **Policy**, including but not limited to crowns and onlays, endodontic services, periodontal services, fixed and removable prosthetics, oral surgery, orthodontic services, maxillofacial prosthetics, implants and any services associated with implants and adjunctive dental services.

   b. **Any Dental Service** or item which is decided by **Delta Dental** not to be **Dentally Necessary**. **Delta Dental** reserves the right to check the **Adult Enrollee’s** dental records; this includes but is not limited to necessary radiographs; oral facial images; models, and financial records to decide whether a **Dental Service** or item meets these criteria.

   c. **Dental Services** for which a **Claim** was not received by **Delta Dental** within twelve (12) months after the date when the **Dental Service** was finished.
d. Duplicative **Dental Services** performed on the same day.

e. **Dental Services** provided by or in institutions owned or operated by the federal government such as Veterans Administration facilities.

f. **Dental Services** rendered outside of the United States and its territories.

g. **Dental Services** for injuries or conditions which are compensable under Workmen's Compensation or Employers Liability laws; temporary disability laws or similar and whether or not the Adult Enrollee claims or receives benefits thereunder; **Dental Services** which are provided by any Federal or State or Provincial government agency, or are provided without cost to the Adult Enrollee by any municipality, county, or political subdivision or community agency, except to the extent such payments are not enough to pay the **Approved Amount** therefor.

h. **Dental Services** performed or items supplied for any conditions, disease, sickness, or injury occurring while the Adult Enrollee is on active duty during military service, or for **Dental Services** or items provided under the laws of the United States of America or of any state of the United States or any foreign country or of any political subdivision of any of the foregoing.

i. A subset of a more **Comprehensive Service** (or a lesser **Dental Service** considered included in the **Comprehensive Service**).

j. Analgesics (such as nitrous oxide) or other euphoric or prescription drugs.

k. **Dental Services** of a trial, experimental or investigational nature.

l. Charges for hospitalization, including hospital visits.

m. Lab tests and/or lab exams and/or medical tests, etc.

n. Specialized techniques including but not limited to swing locks, dolder bars, special staining, halder bars, connector bars, metal bases, cone beam capture imaging, interpretation and manipulation, ridge augmentation, and/or preservation.

o. **Dental Services** submitted for payment as part of a **Claim** which has knowingly inaccurate information pertinent to the **Claim** (such as the **Dental Service** actually rendered, the date of service, the existence of other coverage, or the fee for the **Dental Service**).

p. Tooth preparation; acid etching; temporary restorations and crowns; bases; direct and indirect pulp caps; polishing; caries removal; microabrasion; endodontic working, final treatment, and follow up radiographs; occlusal adjustments; post removal; gingivectomy **In Conjunction With** restorations; impressions; lab fees and material; local anesthesia services
in conjunction with operative or surgical procedures, and other Dental Services which Delta Dental considers to be part of a more Comprehensive Dental Service.

q. Broken appointments.

r. Completion of Claims; copying of radiographs; providing documentation whether or not requested by Delta Dental; and requests for Pre-Treatment Estimate.

s. Periodontal charting.

t. Infection control, sterile surgical setup, OSHA compliance, and other facility charges

u. Treatment rendered by persons other than Dentists. This does not apply to any Dental Services which may be performed according to law by a duly licensed dental hygienist or dental auxiliary if the treatment is performed under the supervision and guidance of the licensed Dentist; in accordance with all applicable governmental rules and the licensed Dentist submits the Claims for such treatment in accordance with all applicable governmental rules. If performed under these circumstances, the Benefit Amount for the Dental Services is determined as if the Dental Services had been rendered by a Dentist.

v. Dental Services or supplies that are cosmetic in nature. These Dental Services include but are not limited to charges for personalized or characterization of dentures.

w. Desensitizing agents, home rinses and gels, toothbrushes, dental floss, personal hygiene items, other preparations and items for home use.

x. Dental Services or supplies for which no charge is made that the Adult Enrollee is legally required to pay or for which no charge would be made if the Adult Enrollee did not have dental coverage.

y. Dental Services for which the Dentist does not normally charge.

z. Dental Services performed by the Dentist for immediate family members of the Dentist such as mother, father, Spouse, children, brother, sister, or for an Adult Enrollee in the Dentist’s household.

aa. Myofunctional therapy.

bb. Dental Services to correct developmental or congenital malformations, replace or repair teeth due to such conditions.

cc. Dental Services or appliances for cosmetic purposes.
dd. **Dental Services** to diagnose or treat jaw joint disorders, such as, but not limited to, myofascial pain syndrome and temporomandibular joint disorders.

e. Occlusal equilibration, occlusal analysis, mounted case analysis, and occlusal adjustment.

ff. **Dental Services** or supplies due to an accidental injury.

gg. Fees which are incurred for any injury or disease arising out of the ownership, maintenance or use of a motor vehicle, except when such charges are excluded from coverage under any automobile insurance policy or program required or provided by statute covering such **Covered Person**, where such exclusion is due to either an optional choice of a medical cost, deductible or an optional designation of the plan as the primary coverage.

hh. **Dental Services** which have not been completed during the **Coverage Period** except as expressly exempted by Section 9.1.

ii. Sales taxes on **Dental Services**.

### 9.0 - OTHER PAYMENT RULES THAT AFFECT YOUR COVERAGE

**Delta Dental** will pay a **Benefit** for only those **Dental Services** that are **Covered Services**. Not all **Dental Services** are covered under this **Policy**. Except for covered **Medically Necessary Orthodontic Services** performed on **Pediatric Enrollees**, **Delta Dental** will not pay a **Benefit** unless the **Patient** is enrolled on the **Completion Date** of the **Dental Services**. **Benefits** are determined based on the date **Dental Services** are finished. The one exception is for **Medically Necessary Orthodontic Services** performed on **Pediatric Enrollees** (see Section 9.1.2.).

#### 9.1 - Dental Services Requiring Multiple Visits

9.1.1 - Some **Dental Services** take multiple visits to complete. Examples include crowns, bridges, removable prosthetics, and endodontic procedures. Except for covered **Medically Necessary Orthodontic Services** performed on **Pediatric Enrollees**, **Delta Dental** pays for **Covered Services** that need multiple visits only upon completion of the **Dental Services**. The **Completion Date** is deemed to be the date of service for these **Dental Services**.
9.1.2 - For Pediatric Enrollees, Delta Dental will first make one payment at the start of covered Medically Necessary Orthodontic Services (the initial payment). That payment will be based on 20% of the total Allowed Amount for the Prior Authorized Orthodontic Services. Medically Necessary Orthodontic Services require Prior Authorization. Where Prior Authorization is required but not obtained, We can apply a penalty of up to 50% of the charges that would otherwise be covered. Delta Dental will make quarterly payments for the balance of the Allowed Amount for those Dental Services. Each quarterly payment will be prorated. For example, if the Dental Service plan is for twenty-four (24) months, Delta Dental will make quarterly payments of one eighth (1/8) of the balance that remains after the initial payment. Quarterly payments will stop at the earlier of the completion of the Dental Services or the date when the Patient is no longer a Pediatric Enrollee.

9.2 - In-Process Treatment

9.2.1 - Examples of the Dental Services which may be performed over more than one visit include, but are not limited to fixed bridgework, full or partial dentures, crowns, and root canal therapy. The Completion Date of Dental Services other than covered Medically Necessary Orthodontic Services performed on Pediatric Enrollees (Section 9.2.2.) must occur before the Coverage Expiration Date in order for them to be due any Benefit under this Policy. The Completion Date is the date of insertion for removable prosthetic appliances; the insertion date for fixed partial dentures and for crowns; onlays; and inlays; is the cementation date no matter what the type of cement used. The Completion Date for root canal therapy is the date the canals are permanently filled.

9.2.2 - Benefits for in process Medically Necessary Orthodontic Services performed on Pediatric Enrollees will be prorated so that Delta Dental pays a Benefit based on the length of time the Pediatric Enrollee is covered under this Policy as compared to the total amount of time for which the Pediatric Enrollee will have received those Dental Services. For example, if the Dental Service plan is for twenty-four (24) months and ten (10) months of treatment have already been performed prior to the Pediatric Enrollee being covered under this policy, Delta Dental will make monthly payments of one fourteenth (1/14) of the balance that remains, based upon the twenty percent (20%) initial payment and monthly calculation described above. Monthly payments will stop at the earlier of the completion of the Dental Services or the date when the Patient is no longer a Pediatric Enrollee.

9.3 - Incomplete Treatment
One Dentist may start a Dental Service, and another Dentist may finish it. If this happens, Delta Dental will pay no Benefit for the Dental Service performed by the Dentist who did not complete the Dental Service. Delta Dental’s payment of a Benefit will only be for the Dental Services rendered by the Dentist who finishes the Dental Service.
10.0 - PRIOR AUTHORIZATIONS, PRE-TREATMENT ESTIMATES, CLAIMS, AND APPEALS

10.1 - Pre-Treatment Estimate
A Dentist may send a Claim to Delta Dental showing the Dental Services he or she recommends for a Covered Person. Delta Dental will then provide an estimate of Benefits under this Policy. We call this a Pre-Treatment Estimate. The Benefit Amount for these Dental Services will depend on Eligibility, and any Benefit Limitations and Exclusions. If the Dentist suggests the need for Dental Services which cost more than $300, ask for a Pre-Treatment Estimate before receiving the Dental Services.

10.2 - Prior Authorization (Applicable to Pediatric Enrollees)
This Policy requires that Pediatric Enrollees obtain Prior Authorization for many Dental Services. Those services are listed in the Appendix to Section 12.0. Where Prior Authorization is required but not obtained, We can apply a penalty of up to 50% of the charges that would otherwise be covered. You or the Dentist must send a request to Delta Dental showing the Dental Services he or she recommends for the Pediatric Enrollee. Delta Dental will provide You and Your Dentist Delta Dental’s decision as to what Benefits, if any, it will pay for those services. The request must contain all of the information Delta Dental requires. Those requirements are located at www.deltadentalcoversme.com.

10.3 - Filing a Claim or a Request for Prior-Authorization
The following is a description of how a Claim should be filed. You or the Dentist will send a Claim on behalf of a Covered Person. If a Covered Person visits a Non-Participating Dentist, the New Jersey Non-Participating Dentist is required to send the Claim for a Covered Person, unless the Covered Person chooses to file the Claim with Delta Dental. In other states, the Covered Person may need to send the Claim for Dental Services performed by a Non-Participating Dentist to Us. Claim forms must be sent to the Covered Person or the Pediatric Enrollee’s Dentist must file a request for Prior Authorization. Claim forms and requests for Prior Authorization for Pediatric Enrollees must be sent to:

c/o Delta Dental of Wisconsin, Inc.
P.O. Box103
Stevens Point, WI 54481-0828

(Policy management and service is provided by Delta Dental of Wisconsin, Inc.)
To be entitled to a Benefit under this Policy, the Claim must be submitted by the Covered Person or by his or her Dentist within twelve (12) months of the date Dental Services are completed. In addition, Dental Services must have been performed within twelve (12) months after We issue a required Prior Authorization for Pediatric Enrollees. Failure to obtain a required Prior Authorization for Dental Services performed on Pediatric Enrollees or to have the Dentist perform the service within twelve (12) months after we issue a Prior Authorization means We can apply a penalty of up to 50% of the charges that would otherwise be covered. Delta Dental must approve the Claim or request for Prior Authorization, deny the Claim or request for Prior Authorization, or ask for more information within the time frames prescribed by law and/or regulation.

10.4 - BENEFITS PAID TO NON-PARTICIPATING DENTISTS
Any Benefit that We pay for Covered Services rendered by a Non-Participating Dentist shall be issued to You in accordance with the timeframe set forth in N.J.S.A. 17:48C-8.1, and We shall, within three (3) days of making that Benefit Payment, provide a notice to the Non-Participating Dentist of the amount and date of the payment and the Dental Services for which the payment was made in response to a Claim. Payments to Non-Participating Dentists may be made directly to You rather than the Dentist.

10.5 - Claims Review and Appeals Procedures
You have the right to appeal any Adverse Benefit Determination.

Examples of Adverse Benefit Determinations include Claim decisions by Delta Dental that a Dental Service is not entitled to a Benefit because it is:

- Not a Covered Service;
- Excluded from coverage;
- Subject to a Benefit Limitation under the Policy;
- Rendered prior to Delta Dental sending a Prior Authorization (where applicable).

The following sections provide a complete description of the Informal Review and Appeals processes.

10.6 - Notice of Adverse Benefit Determination
If a Claim or request for Prior Authorization is denied in whole or in part, Delta Dental will tell You and the Dentist of the denial in writing. We will send an Explanation of Benefits within the time and way required by law and/or regulation.

The Explanation of Benefits will include the following information:

- The specific reason(s) why payment for the Dental Services was denied, including a reference to any specific rules on which the denial is based; whether a specific rule, guideline or protocol was relied upon in making the Adverse Benefit Determination and if so, that a copy will be provided free of charge upon request; and a description of any extra information needed to perfect the Claim as well as the reason why such information is necessary.
• The relevant scientific or clinical judgment will be included if the **Adverse Benefit Determination** is about medical or dental need, experimental treatment, or other similar exclusion or limitation.

• A description of **Delta Dental’s** informal appeal and formal claim appeal processes and the time limits applicable to the processes.

10.7 - Request for Informal Review

If **You** or **Your Dentist** disagrees with **Delta Dental’s Adverse Benefit Determination**, **You** can file a request for informal review within 60 days of the adverse determination. Send it to:

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  c/o Delta Dental of Wisconsin, Inc.
P.O. Box 103
Stevens Point, WI 54481-0828
```

**Policy** management and service are provided by Delta Dental of Wisconsin, Inc.)

**Your** request must include the **Claim** number, name and address of the **Subscriber** and **Covered Person** for whom the **Dental Services** were provided, the date of service, description of **Dental Service**, **Your** signature and date of signature, the date **You** received **Delta Dental’s Adverse Benefit Determination**, the reason(s) why **You** think the determination was wrong and any relevant records and information **You** want **Delta Dental** to consider.

**Delta Dental** will tell **You** in writing of its decision within 60 days after receipt of **Your** request (30 days for requests for **Prior Authorization**). If, after the review, the determination stays adverse, the notice will specify the reason(s). It will also refer to the specific plan provision, guide or protocol upon which the determination was based. It will tell **You** of **Your** right to get free of charge, upon request, all relevant documentation, and describe any voluntary, external appeal procedures as well as **Your** right to bring civil (court) action. If the **Adverse Benefit Determination** was based on medical or dental need or exclusion for experimental treatment, the notice will either provide a reason or offer to provide one free of charge upon request.

**You** do not need to request an informal review. But, **You** must appeal the first decision or the Informal Review decision within 240 days following the mailing date of the first **Adverse Benefit Determination**.

10.8 - Request for Appeal of Adverse Benefit Determination

**You** or **Your Dentist** must ask for a formal review in writing within 240 days of receipt of the first **Adverse Benefit Determination** (whether or not **You** asked for an informal review). Send it to:

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  c/o Delta Dental of Wisconsin, Inc.
P.O. Box 103
Stevens Point, WI 54481-0828
```
(Policy management and service are provided by Delta Dental of Wisconsin, Inc.)

The request for a formal review must include the following:

- Dentist’s name
- Office name, address and license number
- Subscriber’s name
- Subscriber’s member I.D. number and date of birth
- Name and date of birth of the Covered Person for whom the Dental Services were provided
- The Claim number
- The reason(s) why Delta Dental should change its first decision and the specific decision You are seeking.

Include any relevant information or diagnostic materials, and/or a copy of the Claim for the determination You are appealing. You must also sign the request. If the Dentist is authorized to act on Your behalf, he/she must tell Us and include an authorization form. The form can be found at www.deltadentalcoversme.com.

10.9 - Delta Dental’s Review
The review will be conducted by a person who is neither the individual who made the first Claim denial nor the subordinate of such individual. If the review is of an Adverse Benefit Determination based in whole or in part on a decision related to dental need, experimental treatment or a clinical judgment in applying the terms of the Policy, Delta Dental will consult with a Dentist who has appropriate training and experience in the pertinent field of Dentistry and who is neither the person who made the first Claim denial nor the subordinate of such individual. Delta Dental will provide upon request of the claimant the name of any dental consultant whose advice was obtained for the Claim denial, whether or not that advice was relied upon in making the Adverse Benefit Determination which You appealed.

10.10 - Notice of Review Decision
Delta Dental will tell You in writing of its decision on the Formal Appeal within 30 days of its receipt of the appeal. Special events may call for an extension of time for processing. In such cases, written notice of the extension will be supplied to You before the end of the first response time frame required by law and/or regulation. In no event will such extension exceed a period of 60 days from the end of the first response time frame required by law and/or regulation. The extension notice will indicate the special events requiring an extension. It will also indicate the date by which Delta Dental expects to make its decision.

If Delta Dental upholds the Adverse Benefit Determination on appeal, the notice will include the following information:
• The specific reason(s) why payment for the Dental Services was denied, including a reference to any specific rules on which the denial is based; whether a specific rule, guideline or protocol was relied upon in making the Adverse Benefit Determination and if so, that a copy will be provided free of charge upon request; and a description of any extra information needed to perfect the Claim as well as the reason why such information is necessary.

• The relevant scientific or clinical judgment will be included if the Adverse Benefit Determination is about dental need, experimental treatment, or other similar Exclusion or Specific Limitation.

• A description of Delta Dental’s informal appeal and formal Claim appeal processes and the time limits applicable to the processes.

10.11 - Limitations on Legal Action
You must timely file an Adverse Benefit Determination appeal and get Our decision as described in Sections 10.7 and 10.10 above before commencing any legal proceeding challenging any Adverse Benefit Determination. In any event, no legal proceeding shall be brought against Delta Dental for any determination once 36 months have passed from the date of when Dental Services were performed.

10.12 - Authorized Representative
You may authorize a representative to act on Your behalf in pursuing a Claims review or Claims appeal. Delta Dental may require that You name Your authorized representative for Us in writing in advance. For an urgent care Claim, You may name a dental care professional, who is knowledgeable about Your dental condition, to act on Your behalf. We will deal with Your authorized representative, rather than You, for matters involving the Claim or appeal.

10.13 - How to Report Suspicion of Fraud
It is insurance fraud to give false information to Delta Dental to get a larger payment than You are entitled to receive. False Claims include submitting a Claim for a Dental Service not actually done. They also include wrongly describing a Dental Service which was rendered, misrepresenting the amount of the fee the Dentist charged and planned to collect (including failing to make known that the Dentist intends to waive all or part of the Patient’s copayment), or using a wrong date for the actual rendering of the Dental Service.

Insurance fraud hurts everyone. It lowers the funds available to pay genuine claims and raises costs for all people. It has harsh criminal and civil consequences to those who take part in preparing or submitting such claims. We urge You to avoid submitting or participating in the submission of false Claims. Call Delta Dental at 973-285-4167 if You suspect insurance fraud has been committed.
11.0 - GENERAL TERMS AND CONDITIONS

11.1 - Applicable Law
This Policy shall be governed by, and construed under, the laws of the State of New Jersey.

11.2 - No Assignment of Benefits
Neither this Policy, a Claim, nor Benefits paid under this Policy is assignable to a third party. Delta Dental reserves the right to pay any Benefits to Your Dentist as appropriate. This is subject to applicable federal and/or state laws. Any assignment of Your right to payment of a Benefit is void and unenforceable, unless state law requires Us to honor the assignment.

11.3 - Binding Agreement
This Policy is binding on Delta Dental, Covered Persons, and Your respective executors and administrators. By election of coverage or payment of applicable Subscription Charges, all of the terms, covenants, and rules contained in the Policy shall become valid and binding upon You and the Covered Persons enrolled under Your Policy. This Policy shall not bind Delta Dental until (i) Subscription Charges are received by Delta Dental and (ii) Your application has been approved.

11.4 - Entire Agreement
This Policy, the Declaration, any amendments to this Policy, and the completed application attached to this Policy make up the entire agreement between Delta Dental and You. This Policy supersedes all earlier communications, representations, or agreements — either verbal or written — between Delta Dental and You, about the information herein.

11.5 - Equality of Application
This Policy is meant to apply equally to all Covered Persons.

11.6 - Time Limit on Certain Defenses
A material misstatement by You in any application for this Policy will entitle Delta Dental to void this Policy. This action may be taken in the first two years of Your coverage beginning on the Original Effective Date. After this two-year period, this action may be taken only for a fraudulent misstatement and non-payment of Subscription Charges. No statement made by the Subscriber in the application will void this Policy or be used in any legal proceeding unless the application or an exact copy is included with or attached to this Policy.

11.7 - Overpayments
Delta Dental has the right to get back any payment made to a Covered Person or Dentist which is more than the amount the person was entitled to get under this Policy or if the Payment was made to the wrong payee. Delta Dental may offset any such overpayment against any amount which otherwise is due under this Policy.
11.8 - Notices
Any notice sent to Delta Dental shall be sent in writing. Such notice is considered to be delivered when delivery is in person or when sent by registered or certified United States mail return receipt requested, proper postage prepaid, and addressed to:

c/o Delta Dental of Wisconsin, Inc.
P.O. Box 103
Stevens Point, WI 54481-0828

Policy management and service are provided by Delta Dental of Wisconsin, Inc.

11.9 - Force Majeure
In the event Delta Dental is unable to perform its duties hereunder by reason of fire, casualty, lockout, strike, labor condition, riot, war, act of God or by ordinance, law, order, or decree of any legally constituted authority, then this Policy may, at the choice of Delta Dental, be suspended. During any period of suspension, Delta Dental shall not be required to perform any service hereunder. Delta Dental shall not be liable for any damages arising from any event that caused the suspension. If this Policy is suspended because of this provision, Your duty to pay Subscription Charges shall also be suspended for the same period of time.

11.10 - Headings
The headings of sections and paragraphs in this Policy are for convenience and reference purposes. They do not change in any way the meaning or interpretation of any provision of this Policy.

11.11 - Severability
If a court of competent jurisdiction deems any term, provision, endorsement, or condition of this Policy invalid or unenforceable, the same shall be deemed severable from this Policy. The rest of this Policy shall stay in full force and effect. It shall in no way be affected, impaired, or invalidated as a result of such ruling.

11.12 - Limitation of Liability
All Dental Services paid for by Delta Dental shall be in accordance with the accepted dental practices in the community at the time. Delta Dental shall not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice by any officer or employee or by any Dentist or others engaged by him while rendering Dental Services to any Covered Person, but this Section 11.12 shall not in any way absolve Delta Dental from any liability imposed upon it by N.J.S.A 2A: 53A-33. In no case shall any Dentist whom You consult for treatment or who renders treatment to You or a Covered Person be deemed an agent or employee of Delta Dental.
11.13 - Compliance with Laws and Regulations
Any provision of this Policy which does not comply with all pertinent federal and state laws and rules, including, but not limited to, the applicable health care privacy and disclosure provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) shall be unenforceable and the remaining terms shall constitute the Policy. If this Policy, or any part of it, is found not to be in compliance with any pertinent federal or state law or rule, then Delta Dental shall administer this Policy in accordance with federal or state law or rule and change the Policy to correct the noncompliance.

11.14 - Confidentiality and HIPAA Compliance
Delta Dental is a “Covered Entity” under the rules of HIPAA. We will comply with all applicable privacy and security rules of HIPAA about the protected health information of Eligible Persons. This provision shall survive the termination of the Policy.

No agent or representative of Delta Dental, other than an officer or officers designated in this Policy, is authorized to change the Policy or waive any of its provisions.

11.16 - Cash Indemnity
Indemnity in the form of cash will not be paid to any Subscriber except in payment for Dental Services for which Delta Dental was liable at the time of such payment.

12.0 - Prior Authorization Requirements (Applicable Only to Pediatric Enrollees)

12.1.1 - The Dental Services that require Prior Authorization are listed on Appendix A.

12.1.2 - All requirements regarding timeliness of claim submission and inquiry requirements shall apply to all Prior Authorized services. Dental providers shall direct all questions regarding the status of a Prior Authorization request and denials of Prior Authorization to Delta Dental at www.deltadentalcoversme.com.

12.1.3 - Requests for Prior Authorization must include a narrative from the Dentist. That narrative must explain why the Dental Service is Dentally Necessary. For orthodontic services, that narrative must explain why the orthodontic services are Medical Necessity Orthodontic Services as defined in this Policy.

12.1.4 - Requests for Prior Authorization must include the diagnostics for the Dental Service required by Delta Dental. Those requirements are found at www.deltadentalcoversme.com. Delta Dental may change those requirements, but changes will apply only to requests submitted after the change.

12.1.5 - The reference to a Dental Service in this section does not mean that it is otherwise a Covered Service.

12.1.6 - Where Prior Authorization is required but not obtained, We can apply a penalty of up to 50% of the charges that would otherwise be covered.
APPENDIX A to SECTION 12.0
SERVICES REQUIRING PRIOR AUTHORIZATION
Applicable to Pediatric Enrollees

NOTE: Where Prior Authorization is required but not obtained, We can apply a penalty of up to 50% of the charges that would otherwise be covered.

1. Sealant replacement.

2. Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function. Services will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor prognosis.

3. Endodontic services other than Emergency Dental Services. Services will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

4. Periodontal services. Requires submission of diagnostic materials and documentation. Periodontal root planning and scaling – with Prior Authorization, can be considered every six (6) months for a Child with Special Health Care Needs.

5. All dentures, fixed prosthetics (fixed bridges) and maxillofacial prosthetics require Prior Authorization.

6. Denture rebase – following 12 months post denture insertion and subject to Prior Authorization, denture rebase is covered and includes adjustments for first six (6) months following service.

7. Pediatric partial denture – for select cases to maintain function and space for anterior teeth with premature loss of primary anterior teeth, subject to Prior Authorization.

8. Medically Necessary Orthodontic Services including continuation of transfer cases or cases started outside the program (otherwise Orthodontic Services are not covered). Removal can be requested by report as a separate service for Dentist that did not start case and requires Prior Authorization.

9. Behavior management when exceeding the following thresholds based on place of service:
   • One unit equals 15 minutes of additional time:
     • Office or clinic – 2 units
     • Inpatient/outpatient hospital – 4 units
     • Skilled nursing/long term care – 2 units
10. Dental services to be rendered in a hospital or ambulatory surgical center (documentation must include the specific diagnosis and medical conditions that require admission to the hospital or ambulatory surgical center).
Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, New Jersey 07054

Family Dental Policy
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