Your Dental Policy

From Delta Dental of New Jersey, Inc.
Clear Plan from Delta Dental

Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, New Jersey 07054

1-888-899-3734
www.deltadentalcoversme.com

FORM DDNJ-IND-FC1-4/2012

WELCOME

Delta Dental of New Jersey, Inc. ("**Delta Dental**") welcomes **You** and any **Dependents** **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 **Your** dental coverage.

The terms "**You**" and "**Your**" means the person(s) 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 definitions 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 54481-0103

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** at the address shown below. Any **Subscription Charges You** paid will be refunded. If **You** received **Benefits** during the 10-day period, **Subscription Charges** paid will be refunded to **You** less the amounts that **We** paid for **Claims**. 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 as noted in Section 4.3; or
2. Fraud or material misrepresentation made by or with the knowledge of the **Subscriber** or a **Dependent** applying for this **Policy** or making a **Claim** for **Benefits** under this **Policy**; or
3. The **Subscriber** 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. 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. 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.

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: Thomas C. Kahler
Vice President, Underwriting & Actuarial Services

Delta Dental Clear Plan 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 this **Policy** does not cover orthodontic **Services**. Also note that all terms in **bold** print are defined in Section 2.0.

This **Policy** will pay a **Benefit** only for the **Covered Services**. If the **Dental Service You** receive is not a **Covered Service**, no **Benefit** will be paid under this **Policy**. **Covered Services** may not result in payment of a **Benefit** under this **Policy** due to **Benefit Limitations** and **Exclusions**.

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. The **Allowed Amount** will vary depending on whether the **Dentist** is a **Delta Dental Participating Dentist**, a **Delta Dental Participating Specialist**, or a **Delta Dental PPO℠ Dentist.** It will also vary based on the actual fee **Your Dentist** charges for the **Dental Service**. **Our Benefit Amount** will generally be the **Allowed Amount** minus the **Copayment** for the **Covered Service** (for example, the **Copayment** for cleaning check-up is$60.00), so **We** would pay the **Allowed Amount** minus $60.00.

You will pay the **Copayment** that is listed for the **Covered Service** as listed in Section 7.0 of this **Policy**. Because **We** apply the **Copayment** to the **Allowed Amount**, and because there are **Specific Limitations** and there are **Exclusions** that may apply to the **Service You** receive, **We** may pay no **Benefit** toward a **Covered Service** or, pay a **Benefit** that is less than the **Approved Amount**. **You** should read the detail in Sections 7.0 and 8.0. As **We** note in Section 10.1, **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 **Services** that cost less than that.

This **Policy** has <u>no deductible</u> that must be paid in advance of receiving **Benefits** for **Covered Services**. It also has <u>no waiting periods</u> that must be satisfied before being eligible to receive **Benefits** for **Covered Services**, and <u>no annual or lifetime dollar limits</u> on the **Benefits** paid for **Covered Services** under this **Policy**.

Summary of Covered Dental Services **(IMPORTANT NOTE - - Section 7.0 lists the Covered Services as well as the Specific Limitations, Alternate Treatment Limitations and Specific Exclusions that apply to each Covered Service. And, Section 8.0 lists the General Exclusions for Services that apply under this Policy.)**	**Amount Paid by Covered Person (as shown in Section 7.0 of this Policy)**
Preventive & Diagnostic **Dental Services** to evaluate existing dental conditions and to prevent dental disease and abnormalities, such as examinations, cleanings and x-rays.	Fixed Copayment
Basic Restorative **Dental Services** to repair or restore teeth damaged by dental disease, such as amalgam and composite fillings.	Fixed Copayment
Crowns Restoration of teeth with crowns when they cannot be restored with other filling materials.	Fixed Copayment
Endodontics The treatment of teeth with damaged or diseased nerves, such as root canal therapy.	Fixed Copayment
Periodontics The treatment of diseases of the gums and supporting bone, such as scaling and root planing.	Fixed Copayment
Fixed and Removable Prosthodontics **Dental Services** and appliances to replace missing teeth, such as dentures, bridges and implants.	Fixed Copayment
Oral Surgery Tooth extractions and dental surgery, including preoperative and postoperative care.	Fixed Copayment
Adjunctive General Services **Dental Services** include consultations, general anesthesia, and palliative treatment (temporary treatment of dental pain).	Fixed Copayment

To receive **Benefits** for **Covered Services**, **You** must receive services from a **Delta Dental Participating Dentist, a Delta Dental Participating Specialist,** or a **Delta Dental PPO Dentist**. There is no coverage for **Dental Services** provided by a **Non-Participating Dentist**, except a **Benefit** of $50.00 for a **Dental Emergency** as defined in Section 2.0 of this **Policy**.

Table of Contents

	Table of Contents	Page
1.0	USING YOUR DENTAL PROGRAM	6
2.0	POLICY DEFINITIONS	9
3.0	ELIGIBILITY AND ENROLLMENT	13
4.0	SUBSCRIPTION CHARGES, POLICY RENEWAL, AND TERMINATION	15
5.0	CHOOSING A DENTIST	18
6.0	POLICY COVERAGE TERMS	20
7.0	SCHEDULE OF BENEFITS	22
8.0	GENERAL EXCLUSIONS (Applicable To All **Dental Services**)	36
9.0	OTHER PAYMENT RULES THAT AFFECT **YOUR** COVERAGE	40
10.0	PRE-TREATMENT ESTIMATES, CLAIMS AND APPEALS	41
11.0	GENERAL TERMS AND CONDITIONS	45

1.0 – USING YOUR 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. – Participating Dentists

Your Policy lets **You** get **Dental Services** from any **Dentist** who participates with **Delta Dental**. **Benefits are payable** only if **You** use **a Delta Dental Participating Dentist or Delta Dental PPO Dentist.** There is no coverage if **You** or **Your Covered Dependents** get services from a **Non-Participating Dentist** except for a **Dental Emergency**.

This **Policy** lets **You** select a general **Dentist** or pediatric **Dentist** from two **Delta Dental** networks. They are named Delta Dental PPO℠ and Delta Dental Premier®. Before visiting the **Dentist**, check to see whether **Your Dentist** is a **Delta Dental PPO℠ Dentist** or a **Delta Dental Participating Dentist**. This **Policy** also lets **You** select a dental specialist. All **Delta Dental Participating Specialists** in New Jersey are considered **Delta Dental Participating Dentists** for purposes of this **Policy**.

If a **Dental Emergency** occurs and **You** are not able to see a **Delta Dental PPO Dentist** or **Delta Dental Participating Dentist**, this **Policy** provides a **Dental Emergency Benefit** of $50.00 toward the **Dental Service**(s) provided by a **Non-Participating Dentist** if they are **Covered Services** under this **Policy**.

1.3 – Locating a Participating Dentist

Delta Dental offers two easy ways to find a **Delta Dental Participating Dentist** and a **Delta Dental PPO℠ Dentist** 24 hours a day, 7 days a week. **You** can either:

- Call 1-888-899-3734; or
- Access **Our** Website at www.deltadentalcoversme.com

By calling, **You** can get a customized list of **Delta Dental Participating Dentists** and **Delta Dental PPO℠ Dentists** 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 **Delta Dental Participating Dentists** and **Delta Dental PPO℠ 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 **Delta Dental Participating Dentist** and **Delta Dental PPO℠ Dentists** information for the whole country when **You** travel outside of New Jersey.

1.4 – Selecting a Delta Dental Participating Dentist

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

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

- **Delta Dental Participating Dentists** 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 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**.** 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**, **Benefit Limitations**, and **Exclusions**.

If **Your Dentist** submits a proposed treatment plan to **Delta Dental**, **Delta Dental** will supply a **Pre-Treatment Estimate**. 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. **Pre-Treatment Estimates** are not required. But, **Delta Dental** suggests **You** ask **Your Dentist** to send a request for **Pre-Treatment Estimate** for treatment costing $300 or more. 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 for all of the people covered under **Your Policy**. **You** can also print more copies of **Your** ID Card for **You** and/or **Your Covered Dependents**.

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;**

- Finding **Your Copayment** for Covered **Dental Services;** and
- Locating a **Delta Dental Participating Dentist** or a **Delta Dental PPO℠ 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 **Delta Dental Participating 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 non-English speaking and hearing-impaired **Subscribers**.

By Mail
c/o Delta Dental of Wisconsin, Inc.
P.O. Box 103
Stevens Point, WI 54481-0103

(Policy service is provided by Delta Dental of Wisconsin, Inc.)

2.0 – POLICY DEFINITIONS

1. **“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**. This includes **Delta Dental’s** not paying any **Benefit Amount** for the **Dental Service**.

2. **“Allowance”** means the amount of **Delta Dental’s** payment for **Covered Services**. This amount could be zero.

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** that **Delta Dental** determines is sufficient for the diagnosis or treatment of **Your** dental problem.

5. **"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.

6. **“Approved Amount”** means the total fee which the **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 **Covered Person’s** payment obligation.

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

8. “**Benefit Limitations”** are restrictions on the **Benefit Amounts** payable under this **Policy**. **Benefit Limitations** include the following: (a) the limit on the **Approved Amount** for the **Covered Service** specified in Section 5.1; (b) the **Alternate Treatment Limitation** described in Section 6.; (c) the **Copayment Amount** specified in Section 7.0; and (d) the **Specific Limitations** contained in 7.0.

9. **“Benefited As**” refers to when a **Dental Service** is performed or pre-estimated, 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**.

10. **“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.

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

12. "**Civil Union Partner**" means a person who is a party to a **Civil Union**.

13. **"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**.

14. **"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.

15. **"Copayment"** means the amount paid by the **Subscriber** or **Covered Dependent** to a **Delta Dental Participating Dentist, Delta Dental Participating Specialist**, or **Delta Dental PPO Dentist** for a specific **Covered Service** each time it is provided under **Your Policy**.

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

17. **"Coverage Expiration Date"** means midnight on the date that all **Covered Persons** stop being eligible for the **Benefits** under this **Policy**.

18. **"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 **Covered 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** .

19. **"Covered Dependent"** means a **Dependent** who (a) is listed on the application that is a part of this **Policy**; (b) has been accepted by **Delta Dental** as a **Covered Dependent**; and (c) for whom the proper **Subscription Charges** have been paid.

20. **"Covered Person"** means the **Subscriber** and each of his **Covered Dependents**. 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 Dependent** or as of the **Coverage Expiration Date**.

21. **"Covered Service**(s)" are **Dental Services** that are listed under the heading of "Covered Services" in Section 7.0. **Covered Services** are subject to the **Specific Limitations** and **Specific Exclusions** in Section 7.0, and to the **General Exclusions** in Section 8.0, as may be updated from time to time. **Covered Services** are eligible for payment of **Benefits** under this **Policy** subject to applicable **Benefit Limitations** and **Exclusions**.

22. **"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**.

23. **“Delta Dental Participating Dentist”** means a **Dentist** who (a) has a participation agreement in force with **Delta Dental** or (b) has a participation agreement in force with **Another Delta Dental Plan** to accept payments from **Delta Dental** on the basis provided in this **Policy**. For purposes of this **Policy**, a **Delta Dental Participating Dentist** includes **Delta Dental Participating Specialists**. It does not include **Dentists** who also qualify as "**Delta Dental PPO℠ Dentists**" as defined in this **Policy**; they are "**Delta Dental PPO℠ Dentists**" for purposes of this **Policy**.

24. “**Delta Dental Participating Specialist**” means a **Dentist** who has a participating agreement in force with **Delta Dental** or **Another Delta Dental Plan**; (b) holds a current specialty permit in the state where the **Dentist** performs **Dentistry** in periodontics, prosthodontics, endodontics, or oral surgery and limits his or her practice to the respective specialty, and (c) has registered with **Delta Dental** or **Another Delta Dental Plan** as a specialist.

25. **“Delta Dental PPO℠ Dentist”** means a **Dentist** who has a **Delta Dental PPO℠ Dentist** agreement in force with **Delta Dental** or a similar contract with **Another Delta Dental Plan** for **Dentists** in that respective state. **Delta Dental PPO℠ Dentist** does not include a **Delta Dental Participating Specialist** unless that **Dentist** has also signed a **Delta Dental PPO℠ Dentist** agreement with **Another Delta Dental Plan**.

26. **“Dental Emergency”** means the **Dental Services** provided by a **Dentist** that are necessary for the immediate relief of pain, swelling, or infection. If a **Dental Emergency** occurs and **You** are not able to see a **Delta Dental PPO Dentist** or **Delta Dental Participating Dentist**, this **Policy** provides a **Dental Emergency Benefit** of $50.00 toward the **Covered Services** provided by a **Non-Participating Dentist**.

27. **“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.

28. **“Dentist”** means a person duly licensed to practice **Dentistry** in the state or country in which the treatment is rendered.

29. “**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.

30. **"Dependent"** is defined to be the **Subscriber**’s **Spouse**, a former **Spouse** for whom the **Subscriber** is legally liable to provide dental coverage, and each **Dependent Child**. Persons in military service are not eligible to be **Dependents** under this **Policy**.

31. “**Dependent Child**” means children of the **Subscriber**, the **Subscriber’s Spouse** or former **Spouse**. They include stepchildren, foster children, and legally adopted children.

32. “**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.

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

34. “**Explanation of Benefits**” means a computer-generated statement from **Delta Dental** that **You** will receive after **We** process a **Claim** for **You** or **Your Covered Dependents** describing how **Delta Dental** determined **Your Benefit** for the **Dental Services** submitted on the **Claim**.

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

36. **“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.

37. **“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**.

38. **“Patient(s)”** are people who receive the **Dental Services** or a **Pre-Treatment Estimate** for **Dental Services**.

39. **“Policy”** means this document.

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

41. **“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**; and (d) **Copayment**, **Benefit Limitations**, and **Exclusions**.

42. **“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).

43. **“Schedule of Benefits”** is a listing of the **Covered Services,** specific **Copayments**, **Specific Limitations, Specific Exclusions** and **Alternate Treatment Limitations** 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.

44. “**Specific Exclusions**” mean the **Services** listed as **Specific Exclusions** in Section 7.0 as applicable to the **Dental Service**.

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

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

47. **“Subscriber”** means a person who: (a) has filled out and signed the application needed for coverage under the **Policy**; (b)has been accepted by **Delta Dental** for this **Policy**; (c) has paid the proper **Subscription Charges**; and (d) whose coverage stays active.

48. **“Subscription Charge(s)”** means the total premium due for this **Policy**.

49. **“Subscription Rate Type”** is the category Rate for coverage in effect for this **Policy**. **Subscription Charges** are based on the attained age of each **Covered Person** as of the **Coverage Effective Date** and future **Policy Anniversary Dates**. There are three age categories used to decide the **Subscription Charge** Rate for each **Covered Person:** less than age 26; ages 26 to 50; and age 51 and above.

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

51. **“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 **Your Subscription Charges**;
4. are not eligible for company -sponsored or any other group dental coverage;
5. are not actively covered under any type of group or individual dental coverage;
6. are 18 years of age or an emancipated minor; and
7. 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.
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**.

If **You** choose to cover **Your Dependents**, eligibility begins on the first day **You** become covered under **Your Policy**. New **Dependents** can be added under the Changing Coverage section below.

3.1 – Covered Dependents
You may enroll **Your** Dependent(s) in this **Policy**. To do so, **You** must buy the proper type of coverage and the **Dependent** must be:

1. **Your Spouse**;
2. A **Dependent Child**

3.2 – Continued Dependent Coverage
A **Covered Dependent** (**Spouse** and/or Child) 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; or
2. The **Subscriber** and **Spouse** divorce.

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

3.3 – Changing Coverage
You may only change coverage types (e.g., from **Subscriber** Only to Family Coverage) at the **Anniversary Date** of **Your Policy** 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 a **Civil Union** or domestic partnership);
3. birth or adoption of a child;
4. death of a **Covered Person**;
5. a **Covered Dependent's** loss of other dental coverage; or
6. a court orders **You** to give dental coverage to a **Dependent**, even if **You** are not the custodial parent.

Tell **Delta Dental** about any changes to **Your** eligibility status or the status of a **Dependent**, such as the birth of a child within thirty (30) days. If **You** choose not to sign up a **Dependent** 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.
3.4 – Your Coverage Period

Your Coverage Period begins on the **Coverage Effective Date** shown in the **Policy** page attached to this **Policy**. **Your** 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** 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 **Covered Dependents** 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. for all **Covered Dependents**, the last day of the month when the **Subscriber** becomes deceased.

<u>If **Your** coverage under this **Policy** is terminated or cancelled for any reason, and not reinstated by **Us** prior to the **Coverage Expiration Date, You** cannot sign up for a **Delta Dental** individual **Policy** for 24 months from the date of termination or cancellation.</u>

Fraudulent Information
If **You** gave 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 of 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** 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**. **You** may choose to pay future **Subscription Charges** monthly, semi-annually or once a year if paying by credit card. 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
You have a grace period of thirty (30) 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. 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.

4.4 – Non-Payment of Subscription Charges and Reinstatement
Your Policy ends if **You** have not paid the **Subscription Charges** 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 **Your Covered Dependents** 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 **Anniversary Date**. Such changes shall be in effect for all eligible 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** for **You** or for **Your Covered Dependents** during the **Coverage Period**. **You** may do so only of 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; or
6. At the time of **Your Policy** renewal.

For **Your Covered Dependent Spouse**

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

For **Your Covered Dependent** Children

1. **Your Covered Dependent Child** becomes covered under a group dental plan offered by an employer;
2. **Your Covered Dependent Child** dies;
3. **Your Covered Dependent Child** enters military service;
4. **Your Covered Dependent 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**.

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. **You** or a **Covered Dependent** commits fraud or intentional misrepresentation of a material fact, as determined by **Us**;
3. **You** or a **Covered Dependent** lets a person not Covered under this **Policy** to use the I.D. card of anyone Covered under this **Policy**; or
4. **You** or a **Covered Dependent** fails to follow the terms of this **Policy** as determined by **Us**.

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

Claims for a **Dental Service** must be filed within twelve (12) months after the date the **Dental Service** was finished. **You** or **Your Covered Dependent's** will be responsible for payment of any **Dental Services** finished after termination of **Your** or **Your Covered Dependent's** coverage because they are Excluded by Section 8.0 (2)(kk).

5.0 – CHOOSING A DENTIST

With this **Policy**, **You** must use a **Delta Dental Participating Dentist**, a **Delta Dental Participating Specialist**, or a **Delta Dental PPO℠ Dentist** to receive **Benefits**. **Delta Dental** offers two easy ways to find these **Dentists** 24 hours a day, 7 days a week. **You** can either:

- Call 1-888-899-3734; or
- Access **Our** Website at www.deltadentalcoversme.com

Delta Dental Customer Service can also help **You** locate these **Dentists**. **Benefits** are payable only if **You** or **Your Covered Dependents** get **Covered Services** from a **Delta Dental Participating Dentist**, **Delta Dental Participating Specialist**, or a **Delta Dental PPO Dentist**.

5.1 – Delta Dental Participating Dentists, Delta Dental Participating Specialists and **Delta Dental PPO Dentists**

You may select a **Delta Dental Participating Dentist**, a **Delta Dental Participating Specialist**, or a **Delta Dental PPO Dentist**. These **Dentists** agree to provide treatment for **Covered Persons** based on the terms of his or her agreement with **Delta Dental** or **Another Delta Dental Plan**. **Delta Dental Participating Dentists**, **Delta Dental Participating Specialists,** and **Delta Dental PPO Dentists** will fill out and send the **Claim** to **Delta Dental**. They also get payment straight from **Delta Dental**. **You** will not be responsible for more than the specified **Copayment** for the Dental Procedure. **You** will be responsible for the amount not paid by **Delta Dental** under this **Policy**. This includes amounts **Delta Dental** did not pay because the **Dental Services** were not **Covered Services** or due to **Benefit Limitations** or **Exclusions**.

Dentist Type & Network	**Delta Dental PPO℠ Dentist (Delta Dental PPO ℠ network)**	**Delta Dental Participating Dentist (Delta Dental Premier® network) and in New Jersey, Delta Dental Participating Specialists**
Description	**You** are responsible to pay the **Copayment** applicable to the **Covered Service** listed in Section 7.0 of this **Policy**. **Delta Dental** pays the difference between the **Copayment** and the **Approved Amount** applicable for **Delta Dental PPO℠ Dentists.** Since the **Approved Amount** for **Delta Dental PPO Dentists** may be less than the **Approved Amount** for **Delta Dental Participating Dentists**, **Your** out-of-pocket cost for **Services** not covered under this **Policy** or when an **Alternate Treatment Limitation** is applied (see Section 6.6 of this **Policy** for an example) may be less than if you visited a **Delta Dental Participating Dentist**.	**You** are responsible to pay the **Copayment** applicable to the **Covered Service** listed in Section 7.0 of this **Policy**. **Delta Dental** pays the difference between the **Copayment** and the **Approved Amount** applicable to **Delta Dental Participating Dentists**.
Example*	**Delta Dental PPO ℠ Dentist**	**Delta Dental Premier® Dentist and in New Jersey, Delta Dental Participating Specialists**
Dentist Charge for **Dental Services**	$400	$400
Approved Amount for **Dental Service**	$280	$350
Allowed Amount for **Dental Service**	$280	$350
Patient **Copayment** for **Dental Service**	$120	$120
Delta Dental Payment	$160	$230

5.2 – Non-Participating Dentists
Benefits are payable only if **You** or **Your Covered Dependents** get **Covered Services** from a **Delta Dental Participating Dentist, Delta Dental Participating Specialist, or Delta Dental PPO Dentist**. There is no coverage if **You** or **Your Covered Dependents** get services from a **Non-Participating Dentist** except for a **Dental Emergency**. Be sure to talk to **Your Dentist** about any charges **You** may owe before treatment begins.

You can search for a **Dentist** on the **Delta Dental** Website. Select either **Delta Dental Premier®** or **Delta Dental PPO℠** in the Product Selection section (step 1). **Your** coverage gives **You** access to **Dentists** in both networks. The chart below has an example of out-of-pocket costs for **Dental Services** provided by each type of **Dentist**.

6.0 – POLICY COVERAGE TERMS

The following sections outline the **Policy** Terms and the Schedule of **Benefits** . These sections will give **You** information about **Your Coverage Percent** and the **Benefit Limitations** and **Exclusions** as well as **Alternate Treatment Limitations**.

6.1 – Deductibles
This **Policy** does not have a deductible.

6.2 – Benefit Maximum
This **Policy** does not have an annual or lifetime maximum dollar limit on **Benefits** paid for **Covered Services** under this **Policy**. But, there are **Benefit Limitations** and **Exclusions**. Certain **Benefit Limitations** may limit the number of certain **Covered Services** for which a **Benefit** may be provided during a **Coverage Period**.

6.3 – Copayments
This **Policy** has a specified **Copayment** for each **Covered Service**. **You** or **Your Covered Dependent** are responsible for paying the **Copayment** directly to the **Delta Dental Participating Dentist**, **Delta Dental Participating Specialist**, or **Delta Dental PPO Dentist**. **Delta Dental** will pay the balance of the **Approved Amount** directly to the **Delta Dental Participating Dentist**, **Delta Dental Participating Specialist**, or **Delta Dental PPO Dentist.**

6.4 – Waiting Periods
This **Policy** does not have a waiting period that must be satisfied before **Benefits** are paid for **Covered Services**.

6.5 – 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 Schedule 7.0 and 8.0.

6.6 – Alternate Treatment Limitations

A more costly **Dental Service** may be selected by **You** and **Your Dentist** than the one that **Delta Dental** decides is sufficient for the diagnosis or treatment of **Your** condition. This does not mean that **You** or **Your Dentist's** choice of treatment is wrong or insufficient. However, **Benefits** under this **Policy** are based on the least costly **Covered Service** that **Delta Dental** decides is sufficient for the diagnosis or treatment of **Your** 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** plus the **Copayment** 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 **You** may have higher out-of-pocket costs if the **You** select a **Dental Service** that costs more.

For example, **Your Dentist** recommends a **Dental Service** with an **Approved Amount** of $200.00. **Delta Dental** determines that a **Dental Service** with an **Approved Amount** of $150.00 and a **Copayment** of $35.00 is adequate. In this case, **You** are responsible for paying the dentist the **Copayment** of $35.00 for the **Covered Service** plus the difference between the **Approved Amount** of the **Dental Service You** received ($200.00) and the **Dental Service** covered by **Delta Dental** ($150.00), or $85.00 ($50.00 difference in **Approved Amount** plus $35.00 Copayment). This will be reflected on the **Explanation of Benefits You** receive after a **Claim** is processed by **Delta Dental**.

7.0 – SCHEDULE OF BENEFITS

This **Policy** pays **Benefits** for and only for **Covered Services** listed in the following schedules subject to the **Benefit Limitations** as set forth in this Section 7.0. The schedules show for each **Covered Service** whether a **Copayment** applies. 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.

<table>
<tr><th colspan="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.</th></tr>
<tr><th>Copayment</th><th>Covered Services</th></tr>
<tr><td>$60.00 each check up</td><td>Dental checkup - includes one or more of the following Dental Services provided during a dental visit, subject to the Limitations described below.

Examination or evaluation*

Any one (1) of the following Dental Services:*
▪ Cleaning adult and children;
▪ Gross debridement (extensive cleaning after a lapse in dental care); or
▪ Periodontal maintenance (specialized cleaning after periodontal therapy)

Bitewing X-rays*not more than eight (8) bitewing X-rays, all X-rays must be done on the same date of service.

Fluoride – topical application for children through age 14*

*One or more of the above services within a 30 day period will incur one (1) Copayment.</td></tr>
<tr><td colspan="2">Specific Limitations
Dental check-ups are Benefited once (1) every 6 months from the date of service. 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 once (1) in a 6-month period. No allowance will be paid for comprehensive evaluations, including an oral evaluation for a Patient less than three years of age, performed by the Same Dentist within 3 years. Evaluations within 3 years after a Comprehensive 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 health assessments, diagnosis, pulp test (except limited oral evaluations-problem focused) when performed In Conjunction With an oral evaluation, consultation or other professional visit.

When a limited oral evaluation is performed solely in conjunction with and on the same day as palliative treatment, limited x-rays and/or tests to diagnose the condition in order to relieve pain, the Copayment is waived. If any procedure other than previously stated is performed the Copayment for a dental check-up applies.</td></tr>
</table>

Diagnostic and Preventive Services (continued)	
Copayment	**Covered Services**
$60.00 each series	Intraoral complete-mouth series (CMX), periapical, occlusal, and extraoral films
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. Any number or combination of intraoral x-rays, billed for the same date of service that equals or exceeds the **Approved Amount** for a complete series is considered a complete series for payment purposes. No **Benefit** will be paid for intraoral radiographs taken as routine working and final treatment radiographs by the **Same Dentist** for endodontic treatment.	
Copayment	**Covered Services**
$0.00 each	Pulp vitality test
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 a condition requiring urgent care. No **Benefit** will be paid for more than one (1) pulp vitality test per visit.	
Copayment	**Covered Services**
$120.00 each	Space maintainers (includes teeth, clasps, rests and other components) for retaining space when a primary posterior tooth is prematurely lost Recementation of space maintainer and removal of fixed space maintainer
Specific Limitations No **Benefit** will be paid for space maintainers: (a) more than once (1) per -arch in a lifetime; (b) for missing permanent teeth; (c) for missing primary anterior teeth; or (d) for persons age 14 and older. No **Benefit** will be paid for recementation of space maintainers more than once (1) per **Patient** in a lifetime.	
Copayment	**Covered Services**
$30.00 each	Application of sealants
Specific Limitations No **Benefit** will be paid for sealants and preventive resin restorations: (a) for persons age 15 and older; (b) when applied to any tooth surface other than the occlusal surface of permanent molars which are free of restorations (including, sealants placed on the occlusal surface of the same tooth on the same day); and (c) more than once (1) in a twenty four (24)-month period per tooth.	

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; ▪ 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; ▪ Oral pathology laboratory procedures; ▪ Diagnostic casts; ▪ Procedures such as nutritional and tobacco counseling, oral hygiene instructions, risk assessment, and counseling; ▪ 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; and ▪ Procedures mainly for plaque control.

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.	
Copayment	**Covered Services**
$120.00	Amalgam (silver) fillings and composite (tooth colored) fillings
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. Any restoration involving two or more contiguous surfaces should be reported using the appropriate multiple surface restoration code.	
Copayment	**Covered Services**
$120.00	Prefabricated stainless steel and resin crowns
Specific Limitations No **Benefit** will be paid for prefabricated stainless steel or resin crowns when replaced within a 24-month period of time or on permanent teeth after age 12.	

Basic Restorative Services (continued) Specific Exclusions & Alternate Treatment Limitations
The following **Specific Exclusions** and **Alternate Treatment Limitations** apply to all basic restorative **Dental 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; and ▪ Protective restorations. Any restoration involving two or more contiguous surfaces is **Benefited As** one multiple surface restoration.

<table>
<tr><th colspan="2">Restorative – Crowns
Dental Services involving restoration covering or replacing the major part, or the whole of the clinical crown of a tooth.</th></tr>
<tr><th>Copayment</th><th>Covered Services</th></tr>
<tr><td>$750.00</td><td>Indirectly fabricated single crowns (includes post & cores, and core build-ups)</td></tr>
<tr><td colspan="2">Specific Limitations
Only one crown per twelve (12) month period is covered.

No Benefits will be paid for indirectly fabricated single crowns, onlays, post & cores, and core build-ups: (a) for primary (“baby”) teeth; or (b) when replaced on the same day or within 7 years from the date of the prior major restorative Dental Services, even if Delta Dental did not cover the Patient and/or pay a Benefit toward the prior Dental Service.

For purposes of applying this Frequency Limit, implant supported or natural teeth onlays, inlays, indirectly fabricated crowns, fixed partial dentures, removable partial dentures, immediate and complete dentures are counted against themselves and each other.

No Benefit will be paid for a core buildup when performed with or in addition to an amalgam restoration, resin-based composite restoration, inlays, onlays, or any other type of post and core. Core buildups are not benefited within twenty four (24)-months from the date of service of a restoration on the same tooth.</td></tr>
<tr><th>Copayment</th><th>Covered Services</th></tr>
<tr><td>$60.00</td><td>Crown repairs and recementation of crowns, post and cores</td></tr>
<tr><td colspan="2">Specific Limitations
No Benefit will be paid for recementation of crowns, onlays, post and cores: (a) on the same day or within 6 months after the first insertion by the Same Dentist; or (b) more than once (1) in a 12-month period.

No Benefit will be paid for recementation of a post when performed on the same day as a single crown or fixed partial denture recementation.</td></tr>
</table>

Restorative – Crowns (continued) Specific Exclusions & Alternate Treatment Limitations
The following **Specific Exclusions** and **Alternate Treatment Limitations** apply to restorative – crowns and onlays **Specific Exclusions** Any restorative procedure not specifically listed as a **Covered Service**. The following are also specifically **Excluded**: ▪ Inlays and recementation of inlays; ▪ Onlays; ▪ Gold foil restorations; ▪ Copings (considered a specialized technique); ▪ Provisional or temporary or interim crowns; ▪ Any procedures, restorations, or appliances associated with periodontal splinting; ▪ Any restorative procedure not due to decay or fracture; ▪ Removal of posts; and ▪ Veneers No **Benefit** will be paid for indirectly fabricated crowns unless the teeth cannot be restored with silver amalgam or composite resins (or other material approved by **Delta Dental** at its sole discretion). No **Benefit** will be paid for this **Dental Service** unless the tooth cannot be restored by any other means. **Alternate Treatment Limitations** The **Benefit** indirectly fabricated crowns, and posts and cores for children under 12 years of age will be determined based on the **Approved Amount** for prefabricated resin crowns for front teeth or prefabricated stainless steel crowns for back teeth subject to the above **Specific Limitations** and **Specific Exclusions** applicable to prefabricated resin crowns for front teeth or prefabricated stainless steel crowns for back teeth. The **Covered Person** is responsible for difference between the **Approved Amount** for the prefabricated resin crowns for front teeth or prefabricated stainless steel crowns for back teeth and the **Approved Amount** plus the **Copayment** for the **Dental Service** actually rendered.

Endodontics Necessary **Dental Services** for pulpal therapy and root canal therapy to treat or remove the nerves inside the tooth chamber and roots.	
Copayment	**Covered Services**
$500.00	Root canal therapy (initial) and retreatment of root canal therapy
Specific Limitations Root canal therapy is limited to treatment of two (2) teeth in a twelve (12) month period. No **Benefits** will be paid for initial root canal treatment: (a) more than once (1) per lifetime per tooth; (b) for primary teeth; (c) if not finished; or (d) when performed **In Conjunction With** apexification. No **Benefit** will be paid for retreatment of root canal treatment: (a) on the same day or within 24 months after the first root canal was finished; or (b) more than once (1) per tooth in a lifetime. No **Benefit** will be paid for removal of a post, pin(s), old root canal filling material, and the procedures needed to prepare the canals and place the canal filling and root canal therapy when performed **In Conjunction With** endodontic retreatment. No **Benefit** will be paid for intraoral radiographs taken as routine working and final treatment radiographs by the **Same Dentist** for endodontic treatment.	

Endodontics (continued)	
Copayment	**Covered Services**
$100.00	Pulpotomy, pulpal debridement, and partial pulpotomy for apexogenesis

Specific Limitations

No **Benefit** will be paid for pulpotomy, pulpal debridement, and partial pulpotomy for apexogenesis: (a) if not finished; (b) more than once (1) per lifetime per tooth; or (c) when performed by the **Same Dentist** on the same day as root canal treatment. No **Benefit** will be paid for therapeutic pulpotomy for permanent teeth. No **Benefit** will be paid for partial pulpotomy for apexogenesis: (a) for primary teeth; or (b) when performed within 30 days prior to or the same day as root canal treatment or apexification/recalcification.

Copayment	Covered Services
$120.00	Apexification/recalcification, apicoectomy/periradicular surgery, retrograde fillings, and hemisections on permanent teeth

Specific Limitations

No **Benefit** will be paid for apexification/recalcification and hemisections: (a) if not finished; (b) for primary teeth; or (c) more than once per tooth per lifetime.

No **Benefit** will be paid for apicoectomy/periradicular surgery and retrograde fillings: (a) more than once (1) per root in a lifetime; or (b) for primary teeth.

No **Benefit** will be paid for root amputation: (a) more than once (1) per root in a lifetime; (b) when performed by the **Same Dentist** on the same date on the same root as an apicoectomy; or (c) for primary teeth.

Endodontics
Specific Exclusions & Alternate Treatment Limitations

The following **Specific Exclusions** and **Alternate Treatment Limitations** apply to endodontic services:

Specific Exclusions

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

- Pulp caps;
- Non-surgical treatment of root canal obstruction;
- Internal repair of perforation defects;
- Endodontic endosseous implant;
- Intentional reimplantation;
- Surgical procedure to isolate tooth with rubber dam;
- Canal preparation and fitting of preformed dowel and post;
- Any endodontic procedures related to implants, overdentures or inoperable or fractured teeth;
- Temporary restorations and routine postoperative visits; and
- Pulpal regeneration

Alternate Treatment Limitations

The Benefit for incomplete endodontic treatment will be determined based on the **Benefit Amount** for palliative treatment subject to the **Specific Limitations** and **Specific Exclusions** applicable to palliative treatment. The **Covered Person** is responsible for difference between the **Benefit Amount** for the palliative treatment and the **Approved Amount** plus the **Copayment** for the **Dental Service** actually rendered.

<table>
<tr><th colspan="2">Periodontics
Necessary Dental Services to treat diseases of the tissues (gums) and bone supporting the teeth.</th></tr>
<tr><th>Copayment</th><th>Covered Services</th></tr>
<tr><td>$120.00</td><td>Periodontal scaling and root planing</td></tr>
<tr><td colspan="2">Specific Limitations
No Benefit will be paid for periodontal scaling and root planing: (a) more than once (1) per quadrant on the same day or within twenty-four (24) months; or (b) on the same day or within 30 days before surgery or 90 days following periodontal surgery when performed by the Same Dentist. Scaling and root planing in the absence of 4mm pockets is Benefited As a prophylaxis.</td></tr>
<tr><th>Copayment</th><th>Covered Services</th></tr>
<tr><td>$225.00</td><td>Gingivectomy; crown exposure; gingival flap; apically repositioning flap procedure.</td></tr>
<tr><td colspan="2">Specific Limitations
Gingivectomy; crown exposure, gingival flap, apically repositioning flap procedure

No Benefit will be paid for surgical periodontal treatment, including any surgical re-entry (gingivectomy, flap surgery, and apically repositioning flap procedure): (a) more than once (1) in any combination in the same area of the mouth on the same day or within thirty-six (36) months except soft tissue grafts; (b) when performed for pre-restorative and crown lengthening) purposes, or (c) in the absence of 5mm pockets.

No Benefit will be paid for soft and connective tissue grafts when more than one of the same or different type of soft and/or connective tissue graft is performed on the same day or within 36 months in the same part of the mouth.

No Benefit will be paid for apically repositioned flaps, regenerative procedures, soft and connective tissue grafts, and/or osseous grafts when more than two (2) of any combination of these procedures is performed within any given quadrant are performed on the same date of service.</td></tr>
<tr><th>Copayment</th><th>Covered Services</th></tr>
<tr><td>$750.00</td><td>Osseous surgery, clinical crown lengthening.</td></tr>
<tr><td colspan="2">Specific Limitations
No Benefit will be paid for osseous surgery and clinical crown lengthening: (a) more than once (1) in any combination in the same area of the mouth on the same day or within thirty-six (36) months except soft tissue grafts; (b) when performed for pre-restorative and crown lengthening) purposes; or (c) in the absence of 5mm pockets.</td></tr>
</table>

Periodontics (continued)	
Copayment	**Covered Services**
$400.00	Other surgical periodontal procedures, including soft tissue grafts, distal or proximal wedge procedures, and combined connective tissue and double pedicle grafts.

Specific Limitations

No **Benefit** will be paid for other surgical periodontal procedures, including soft tissue grafts, distal or proximal wedge procedures, ad combined connective tissue and double pedicle grafts: (a) more than once (1) in any combination in the same area of the mouth on the same day or within thirty-six (36) months except soft tissue grafts; (b) when performed for pre-restorative and crown lengthening) purposes; or (c) in the absence of 5mm pockets.

No **Benefit** will be paid for soft and connective tissue grafts when more than one of the same or different type of soft and/or connective tissue graft is performed on the same day or within 36 months in the same part of the mouth.

Periodontics
Specific Exclusions & Alternate Treatment Limitations

The following **Specific Exclusions** and **Alternate Treatment Limitations** apply to periodontic services:

Specific Exclusions

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

- Anatomical crown exposure, provisional splinting;
- Localized delivery of antimicrobial agents, curettage and mucogingival surgery;
- Periodontal charting as a separate procedure;
- Unscheduled dressing change; and
- Laser disinfection and laser assisted new attachment procedures

No **Benefit** will be paid for less **Comprehensive** procedures when performed on the same day in the same part of the mouth as a more **Comprehensive** procedure as listed in the following hierarchy (most **Comprehensive** to least **Comprehensive**):

- Osseous surgery;
- Clinical crown lengthening;
- Apically positioned flap;
- Surgical revision;
- Gingival flap;
- Distal or proximal wedge;
- Anatomical crown exposure;
- Gingivectomy;
- Scaling and root planing;
- Debridement;
- Periodontal maintenance; and
- Prophylaxis

Periodontics (continued)
Specific Exclusions & Alternate Treatment Limitations

The following **Dental Services** are **Benefited As** quadrants or partial quadrant procedures:

- Gingivectomy, scaling and root planing qualify for the full quadrant **Benefit** if four or more diseased teeth distal to the midline are treated. Tooth bounded spaces are not counted in making this determination. When these periodontal procedures do not meet all of these criteria they are **Benefited As** a partial quadrant; and

- Gingival flap procedures and osseous surgery qualify for the full quadrant **Benefit** if four or more diseased teeth or tooth bounded spaces distal to the midline are treated. A tooth bounded space counts as one space despite the number of teeth that would normally exist in the space. When these procedures do not meet all of these criteria the **Benefit** is limited to a partial quadrant.

No **Benefit** will be paid for postoperative care and/or finishing procedures (on the same day or within 90 days of periodontal surgery or scaling and root planing).

No **Benefit** will be paid for periodontal procedures not performed for natural teeth such as but not limited to being performed **In Conjunction With** implants, ridge augmentation and/or preservation, extraction sites, periradicular surgery.

No **Benefit** will be paid for prophylaxis and incidental scaling and root planing procedures by the **Same Dentist** when performed on the same day as periodontal maintenance.

No **Benefit** will be paid for prophylaxis and/or periodontal maintenance if the **Services** are performed by the **Same Dentist** during the time period beginning 14 days before and ending 90 days after a scaling and root planing or other periodontal treatment.

No **Benefit** will be paid for biologic materials to aid in soft and osseous tissue regeneration on the same day as other periodontal regenerative and grafting procedures except when reported only with gingival flap procedures or osseous surgery.

No **Benefit** will be paid for guided tissue regeneration on the same day as soft tissue grafts in the same surgical area.

No **Benefit** will be paid for routine prophylaxis (teeth cleaning) when provided **In Conjunction With** periodontal scaling and root planing. No **Benefit** will be paid for periodontal maintenance except after active periodontal therapy (surgical or non-surgical) has been performed.

Prosthodontics – Fixed and Removable **Dental** Services to replace missing permanent teeth (not including third molars) where the chewing function is impaired.	
Copayment	**Covered Services**
$750.00	Removable complete and partial dentures
Specific Limitations No **Benefit** will be paid for removable complete and partial dentures: (a) more than once in a 7-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. No **Benefit** will be paid for removable partial dentures with cast metal framework for **Patients** under age [16].	
Copayment	**Covered Services**
$750.00 per tooth	Fixed partial dentures (bridges), including retainers (crowns) pontics, core buildups, and post and cores
Specific Limitations No **Benefit** will be paid for fixed partial dentures (bridges), including retainers (crowns) pontics, core buildups, and post and cores: (a) more than once (1) in a 7-year period from the date of prior insertion; or (b) if the existing fixed partial denture is satisfactory or can be made satisfactory. No **Benefit** will be paid for core buildups when performed **In Conjunction With** restorations, inlays, onlays, or post and core of any type.	
Copayment	**Covered Services**
$60.00	Adjustment to complete or partial removable dentures; tissue conditioning; implant prosthesis repair; implant abutment repair.
Specific Limitations No **Benefit** will be paid for adjustments, repairs, relines, rebases and tissue conditioning to removable complete and partial dentures on the same day or within 6 months of insertion of the denture (except in the case of immediate dentures) by the **Same Dentist**. No **Benefit** will be paid for any combination of repairs, relines, rebases, and tissue conditioning more than twice (2) per denture unit on the same day or within 12 months. No **Benefit** will be paid for adjustments: (a) when performed by the **Same Dentist** on the same day or within 6 months of a reline or rebase; (b) more than once (1) on the same day; or (c) more than twice (2) within 12 months. No **Benefit** will be paid for a reline when performed by the **Same Dentist** on the same day or within six months of a rebase. No **Benefit** will be paid for tissue conditioning if performed on the same date of service as the denture is delivered or a reline/rebase is delivered.	

Prosthodontics – Fixed and Removable (continued)	
Copayment	**Covered Services**
$120.00	Repairs, reline, rebase complete or partial removable dentures; Single implant removal; Recement and repair fixed bridgework.

Specific Limitations

No **Benefit** will be paid for recementation of fixed partial dentures (bridges) and single implant abutments or crowns: (a) on the same day or within 6 months of fixed partial denture cementation by the **Same Dentist;** or (b) more than once (1) on the same day or within 12 months.

No **Benefit** will be paid for post recementation when performed on the same day as a single crown or fixed partial denture recementation.

No **Benefit** will be paid for repair of fixed partial dentures (bridges): (a) on the same day or within 6 months of insertion of the first fixed partial denture by the **Same Dentist;** or (b) more than twice (2) in 36 months from then on.

No **Benefit** will be paid for a reline when performed by the **Same Dentist** on the same day or within 6 months of a rebase. No **Benefit** will be paid for adjustments, repairs, relines, rebases and tissue conditioning to removable complete and partial dentures on the same day or within 6 months of insertion of the denture (except in the case of immediate dentures) by the **Same Dentist**.

Copayment	Covered Services
$2,500.00 per implant	Surgical placement of implant body. Includes the abutment, if applicable, and the implant crown.

Specific Limitations

Replacement of one (1) missing tooth either by single endosseous (root form) implant or three (3) unit bridge is covered per twelve (12) month period. No **Benefit** will be paid for replacement of implants, abutments and implant crowns: (a) more than once (1) in a 7 year- period from the date of prior insertion; or (b) if the existing implant, abutment or implant crown is satisfactory or can be made satisfactory.

Prosthodontics – Fixed and Removable
Specific Exclusions & Alternate Treatment Limitations

The following **Specific Limitations**, **Specific Exclusions** and **Alternate Treatment Limitations** apply to fixed and removable prosthodontic services.

Specific Limitations

This **Policy** covers one prosthodontic device or appliance in a 12-month period. **For purposes of determining frequency limitations; implant supported or natural tooth inlays; onlays; indirectly fabricated crowns; veneers; fixed partial dentures; removable partial dentures; immediate and complete dentures are counted against themselves and each other**.

Prosthodontics – Fixed and Removable (continued)
Specific Exclusions & Alternate Treatment Limitations

Specific Exclusions

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

- Interim complete and partial dentures;
- Overdentures;
- Maxillofacial prosthetics;
- Any procedures; restorations; or appliances associated with periodontal splinting;
- Interim or provisional pontics and retainers, connector bars, stress breakers, precision attachments, copings, and pediatric fixed partial dentures;
- Pontics exceeding the normal complement of teeth; and
- Replacement of missing natural teeth using more than the normal amount of retainers for the span.

The maximum **Benefit Amount** that will be paid for repair, and/or reline, and/or rebase, and/or adjustment of a fixed or removable partial denture or complete denture or combination exceeds is one-half the **Benefit Amount** that would be payable under this **Policy** for a new appliance. The maximum **Benefit Amount** that will be paid for replacing all teeth and acrylic on a cast metal removable partial denture framework is two-thirds the **Benefit Amount** that would be payable under this **Policy** for a new appliance.

No **Benefit** will be paid for repair of a fixed partial denture if the payment would exceed one-half of the **Benefit** that would be payable under this **Policy** for a new appliance. No **Benefit** will be paid for implants or any procedures, restorations, appliances and/or crown and fixed partial denture associated with periodontal splinting. No **Benefit** will be paid for a (posterior) fixed partial denture if performed **In Conjunction With** an Allowance for a partial denture in the same arch within the preceding 5-year period. No **Benefit** will be paid for fixed partial dentures bridges and removable cast partial dentures for **Patients** less than sixteen 16 years of age.

Alternate Treatment Limitations

No **Benefit** will be paid for a fixed partial denture unless use of a removable prosthetic device is not sufficient. If a removable device is sufficient, the **Benefit** will be determined based on the **Benefit Amount** for a standard removable partial denture subject to the above **Specific Limitations** and **Specific Exclusions** applicable to a standard removable partial denture. The **Covered Person** is responsible for the difference between the **Benefit Amount** for the standard removable partial denture and the **Approved Amount** for the **Dental Service** actually rendered.

When more than three teeth (except third molars) are missing in an arch, the **Benefit** for a fixed partial denture will be determined based on the **Benefit Amount** for a removable partial denture subject to the above **Specific Limitations** and **Specific Exclusions** applicable to a standard removable partial denture. The **Covered Person** is responsible for the difference between the **Benefit Amount** for the removable partial denture and the **Approved Amount** for the **Dental Service** actually rendered.

The **Benefit Amount** for personalized restoration, specialized techniques, such as but not limited to precision attachments, overdentures , and stress breakers as opposed to standard procedures will be determined based on the **Benefit Amount** for the standard procedure subject to the **Specific Limitations** and **Specific Exclusions** applicable to the standard procedure. The **Covered Person** is responsible for the difference between the **Benefit Amount** for the standard procedure and the **Approved Amount** for the **Dental Service** actually rendered.

The **Benefit Amount** for a indirect resin based composite or porcelain-ceramic fixed partial denture will be determined based on the **Benefit Amount** for the porcelain fused to high noble metal fixed partial denture subject to the **Specific Limitations** and **Specific Exclusions** applicable to the porcelain fused to high noble metal fixed partial denture. The **Covered Person** is responsible for the difference between the **Benefit Amount** for the porcelain fused to high noble metal fixed partial denture and the **Approved Amount** for the **Dental Service** actually rendered.

<table>
<tr><td colspan="2">Oral Surgery
Dental Services for the extraction of teeth, as well as minor surgical preparation of the mouth for insertion of dentures.</td></tr>
<tr><th>Copayment</th><th>Covered Services</th></tr>
<tr><td>$120.00 per tooth</td><td>Non-surgical extraction of teeth</td></tr>
<tr><th>Copayment</th><th>Covered Benefit(s)</th></tr>
<tr><td>$225.00 per tooth</td><td>Surgical removal of erupted tooth, removal impacted tooth - soft tissue, removal impacted tooth – partial bony, removal impacted tooth complete bony, removal impacted tooth – complete bony with complications, surgical removal residual roots.</td></tr>
<tr><td colspan="2">Specific Limitations
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.

No Benefit will be paid for intraoral incision and drainage when performed by the Same Dentist in the same surgical area on the same date of service as endodontics, extractions, palliative treatment or other definitive procedure.

No Benefit will be paid for routine postoperative care and treatment of dry socket: (a) when performed by the Same Dentist who performed the surgery; or (b) more than once (1) per visit.

No Benefit will be paid for extraction, coronal remnants – deciduous tooth when performed by the Same Dentist in the same surgical area on the same date of service as any other surgery.

No Benefit will be paid for root recovery when performed by the Same Dentist in the same surgical area on the same day as a surgical extraction.

Extractions of impacted teeth are Benefited As determined by the anatomical position of the tooth rather than the surgical procedure necessary for removal.</td></tr>
<tr><th>Copayment</th><th>Covered Services</th></tr>
<tr><td>$200.00</td><td>General anesthesia when administered in a dental office by a Dentist licensed to perform this service.</td></tr>
<tr><td colspan="2">Specific Limitations
No Benefit will be paid for general anesthesia or intravenous sedation: (a) unless medically necessary in conjunction with covered oral surgical procedures, periodontal surgery, or periapical surgery that are Covered Services, or unless necessary due to concurrent medical conditions; and/or (b) to the extent it exceeds 1.5 hours per date of service.</td></tr>
</table>

Oral Surgery (continued) Specific Exclusions & Alternate Treatment Limitations

The following **Specific Exclusions** and **Alternate Treatment Limitations** apply to Oral Surgery services.

Specific Exclusions
Any oral surgery service that is not a **Covered Service**. The following are specifically **Excluded**:

- Any oral surgical procedure related to implants, overdentures, ridge augmentation and/or preservation, transplants or intentional reimplantation, other specialized techniques, oral antral fistula closure, closure of a sinus perforation, tooth transplantation, exfoliative cytology, surgical repositioning, surgical placement of temporary anchorage devices, complicated vestibuloplasty, surgical excision of lesions, surgical incision (except intraoral excision and drainage), treatment of fractures, repair procedures except those listed as covered, tooth mobilization, appliance or splint removal treatment of temporal mandibular dysfunction and orthognathic surgery, coronectomy harvest of bone for use in grafting, and plasma or platelet rich protein (PRP) therapies;

- Any oral and maxillofacial surgical procedure for which the **Covered Person** is covered by another policy including, but not limited to a medical policy, if the other coverage makes a payment sufficient to pay the **Approved Amount** for the procedure; and

- Placement of a device to aid eruption, transseptal/supra crestal fiberotomies; and surgical access of an unerupted tooth.

Adjunctive General Services Other Dental Services	
Copayment	**Covered Services**
$60.00 **$100.00**	Palliative treatment Fixed partial denture sectioning

Specific Limitations

No **Benefit** will be paid for Palliative treatment: (a) when any **Dental Service** other than limited radiographs, tests, evaluations, consults, and visits necessary to diagnose the emergency condition is performed by the Same **Dentist** on the same date; or (b) more than once (1) per date of service; and/or c), more than 4 within a 12-month period.

No **Benefit** will be paid for fixed partial denture sectioning when performed **In Conjunction With** removing and replacing a fixed prosthesis.

No **Benefit** will be paid for routine post -operative care, routine post -operative radiographs, and routine post-operative evaluations when performed by the **Same Dentist** as rendered the operative care.

No **Benefit** will be paid for treatment of dry socket: (a) when performed by the **Same Dentist** who performed the surgery; or (b) more than once (1) per visit.

Adjunctive General Services (continued)	
Copayment	**Covered Services**
$200.00	General anesthesia and IV sedation
Specific Limitations No **Benefit** will be paid for general anesthesia or intravenous sedation: (a) unless medically necessary **In Conjunction With** covered oral surgical procedures, periodontal surgery, or periapical surgery, or unless necessary due to concurrent medical conditions; and/or (b) to the extent it exceeds 1.5 hours per date of **Dental Service**. No **Benefit** will be paid for intravenous sedation when the drug is not administered intravenously to achieve sedation.	

Adjunctive General Services
Specific Exclusions & Alternate Treatment Limitations

The following **Specific Exclusions** and **Alternate Treatment Limitations** apply to adjunctive general **Dental Services**.

Specific Exclusions
Any adjunctive **Dental Service** not listed as a **Covered Service** is **Excluded**. The following are also specifically **Excluded**:

- Anesthesia: local; regional and trigeminal block; analgesia; anxiolysis; nitrous oxide; non-intravenous conscious sedation;
- Professional visits: house, hospital and ambulatory surgical center calls; office visits; hospitalization costs; case presentation and treatment planning;
- Drugs: euphoric or prescription drugs, or writing prescriptions, therapeutic parenteral drugs, or other drugs or medicaments;
- Miscellaneous: desensitizing procedures, behavior management, occlusal guard, repair, reline and adjustment of occlusal guard, athletic mouthguards, occlusal analysis including mounted case, occlusal adjustment, enamel microabrasion, odontoplasty, internal and external bleaching;
- Anesthesia and/or IV sedation time before the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol; and
- Anesthesia and/or IV sedation time after the **Patient** may be safely left under the observation of trained personnel and the doctor may safely leave the room to look after other **Patients** or duties.

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**.

1. A **Covered Person** 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 **Covered Person**. 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 orthodontic services, and maxillofacial prosthetics.

    b. **Dental Services** for which a **Claim** was not submitted within twelve (12) months after the date when the **Dental Service** was finished except for any oral and maxillofacial surgical procedure for which the **Covered Person** is covered by another policy including, but not limited, to a medical policy, if the **Dental Service** is submitted to **Us** within twelve (12) months after the date that carrier issued its **Claim** determination.

    c. Duplicative **Dental Services** performed on the same day.

    d. **Dental Services** for injuries or conditions which are compensable under Workmen's Compensation or Employer's Liability laws; **Dental Services** which are provided by any Federal or State or Provincial government agency, or are provided without cost to the **Covered Person** 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.

    e. **Dental Services** performed or items supplied for any conditions, disease, sickness, or injury occurring while the **Covered Person** 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.

    f. **Dental Services** covered in whole or in part by the **Covered Person's** medical benefit program to the extent otherwise specifically allowed by this **Policy**.

    g. **Dental Services** considered by **Delta Dental** to be a part of a more **Comprehensive Service**.

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

    i. Inlays and onlays.

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

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

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

m. Charges for hospitalization, including hospital visits.

n. Exploratory surgery or unsuccessful attempts at extractions.

o. Lab tests and/or lab exams and/or medical tests.

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

q. **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**).

r. Any **Dental Service** or item which is decided by **Delta Dental** not to be necessary, appropriate, or meeting generally accepted standards of care, and/or lacking a reasonable prognosis for the treatment of the **Covered Person's** condition, disease or injury. **Delta Dental** reserves the right to check the **Covered Person'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.

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

t. Broken appointments.

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

v. Periodontal charting.

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

x. 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, dental assistant or other 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

governmental rules. If performed under these circumstances, the **Benefit Amount** for the **Services** is determined as if the **Dental Services** had been rendered by a **Dentist**.

y. **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.

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

aa. Onlays, crowns, veneers, prosthetic retainers, and pontics post and cores, and core buildups are limited to one per tooth per benefit period [60] [84] months without regard to whether the tooth has been sectioned.

bb. Desensitizing agents; home rinses and gels, other preparations for home use.

cc. Fees for **Dental Services** or supplies for which no charge is made that the **Covered Person** is legally required to pay or for which no charge would be made if the **Covered Person** did not have dental coverage.

dd. **Dental Services** performed by the **Dentist** for immediate family members of the **Dentist** such as mother, father, **Spouse**, children, brother, sister.

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; procedures, appliances, or restorations for cosmetic purposes; procedures, appliances, or restorations to increase vertical dimension; restore occlusion or repair tooth structure lost by attrition; erosion; corrosion; abfraction; or related to bruxism; TMJ; TMD; or occlusal equilibration, occlusal analysis and mounted case analysis, or occlusal adjustment.

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

ii. 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.

jj. **Dental Services** which have not been completed.

kk. **Dental Services** which have not been completed during the **Coverage Period**.

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**. **Delta Dental** will not pay a **Benefit** unless **You** are enrolled on the start and **Completion Date** of the **Dental Services**. **Benefits** are determined based on the date **Dental Services** are finished.

9.1 – Dental Services Requiring Multiple Visits

Some **Dental Services** take multiple visits to complete. Examples include crowns, bridges, removable prosthetics, and endodontic procedures. **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**.

9.2 – In-Process Treatment

Dental Services started before **Your Coverage Effective Date** under this **Policy** are not entitled to any **Benefit**. 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 these **Dental Services** 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.

9.3 – 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**.

9.4 – Dental Services Covered Under a Medical Policy

To sign up for this **Policy**, **You** or **Your Dependents** cannot be covered under another dental policy . But, **You** may have medical coverage for **You** and/or **Your Dependents**. **Your** medical policy may cover certain **Dental Services** such as oral surgery which is a **Covered Service** under this **Policy**. If **Your** medical policy covers any **Dental Services** which could also be **Covered Services** under this **Policy**, then this **Policy** is considered secondary. This **Policy's Benefit** shall be decided after **Your** medical policy has made its **Claim** decision. **You** must send the **Claim** determination **You** received from **Your** medical policy indicating its payment, if any, and any fee limitations the plan may have when submitting a **Claim** for those **Dental Services** under this **Policy**.

10.0 – 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 **You**. **Delta Dental** will then provide an estimate of **Benefits** under **Your Policy**. **We** call this a **Pre-Treatment Estimate**. **You** do not need prior approval of **Dental Services** under this **Policy**. The **Benefit Amount** for these **Dental Services** will depend on eligibility, and any **Benefit Limitations** and **Exclusions**. If **Your Dentist** suggests the need for **Dental Services** which cost more than $300, ask for a **Pre-Treatment Estimate** before receiving the **Dental Services**. **You** can also ask for a **Pre-Treatment Estimate** for **Dental Services** that cost less than $300.

10.2 – Filing a Claim

The following is a description of how a **Claim** is processed. A **Delta Dental Participating Dentist, Delta Dental Participating Specialist,** or **Delta Dental PPO℠ Dentist**, the **Dentist** will send a **Claim** on **Your** behalf. **Claim** forms must be sent to:

c/o Delta Dental of Wisconsin, Inc.
P.O. Box103
Stevens Point, WI 54481-0103

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

To be entitled to a **Benefit** under this **Policy**, the **Claim** must be submitted by **You** or **Your** Dentist within twelve (12) months of the date **Dental Services** are completed. **Delta Dental** must approve the **Claim**, deny the **Claim**, or ask for more information within the time frames prescribed by law and/or regulation.

10.3 – 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; or
- Subject to a **Benefit Limitation** under the **Policy**.

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

10.4 – Notice of Adverse Benefit Determination
If a **Claim** 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 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.

10.5 – 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:

c/o Delta Dental of Wisconsin, Inc.
P.O. Box 103
Stevens Point, WI 54481-0103

(**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. 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 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**.

10.6 – 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:

c/o Delta Dental of Wisconsin, Inc.
P.O. Box 103
Stevens Point, WI 54481-0103

(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.deltadentalnj.com under "Forms."

10.7 – 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.

10.8 – 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.

10.9 – Limitations on Legal Action
You must timely file an **Adverse Benefit Determination** appeal and get **Our** decision as described in Sections 10.3, 10.4, 10.5, 10.6, 10.7, and 10.8 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.

10.10 – 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.

10.11 – 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 **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.

11.3 – Binding Agreement
This **Policy** is binding on **Delta Dental** and **You**, **Your Covered Dependents**, 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 **Your Covered Dependents**. 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 **Coverage 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 **Subscriber**, **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 to **You** 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 54481-0103

(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** provided 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 **Your Dependents** 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**.

11.15 – Waiver of Policy Provisions
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.

Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, New Jersey 07054

Individual Dental Policy
FORM DDNJ-IND-FC1-4/2012

NJ Prompt Payment Requirements

Delta Dental of New Jersey's insurance coverage is subject to the Prompt Payment laws and regulations of the State of New Jersey.

The Prompt Pay regulations require us to post what you need to give us with your claim for payment for services. You must provide all of the information requested in the standard ADA claim form. You must also provide us the information and/or documentation that we require for the particular service(s) you are requesting payment for. The chart containing that required information and documentation is available at www.deltadentalcoversme.com/prompt-payment or by clicking here. We will also provide you a paper copy of that chart at your request.

Please note that the current law and regulations require that we process and issue determinations for electronic claims within thirty (30) days and paper claims within forty (40) days ("the claim processing period") whenever they contain all of the information and documentation that we require that you submit as part of the claim (see above). If we determine that the claim fails to provide all of the required information and documentation (an "incomplete claim"), we must issue a notice to you and your dentist that informs you of the missing information/documentation within the claim processing period. If you have provided us all of the required information/documentation for some of the services submitted for payment on that claim, we will process the claim for those services within the claim processing period. Once you or your dentist has provided us all of the required information/documentation for a previously incomplete claim, we are required to process that claim and issue our determination within the claims processing period. If we fail to process a complete claim within the applicable claims processing period we must pay interest on the amount we owe on the claim with interest computed at the annual rate of 10% either with the claim payment or within fourteen days thereafter.

DELTA DENTAL

Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

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

Delta Dental:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Jennifer Morrison, Compliance Manager, 2801 Hoover Road, Stevens Point, WI 54481, Phone: 715-344-6087, TTY: 877-287-9039, Fax: 715-344-9058, *jmorrison@deltadentalwi.com*.

If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Jennifer Morrison, Compliance Manager, 2801 Hoover Road, Stevens Point, WI 54481, Phone: 715-344-6087, TTY: 877-287-9039, Fax: 715-344-9058, *jmorrison@deltadentalwi.com*. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Jennifer Morrison, Compliance Manager, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.