DELTA DENTAL®

Individual Dental Plan Booklet

Your all-in-one guide to understanding your dental plan.

Contact Information for Delta Dental of Illinois

If You have any questions regarding Your dental plan or the items outlined in this booklet, please contact Us using the information below.

General Mailing Address and Phone Number

Delta Dental of Illinois
PO Box 103
Stevens Point, WI 54481
855-335-8267

Customer Service Information

Phone Number: 855-335-8267
E-mail: customerservice@deltadentalil.me
Hours of Operation: Monday through Friday, 8 a.m. to 5 p.m., Central Time

Claims Information

Mailing Address for Claim Forms:

DDIL- Individual
P.O. Box 103
Stevens Point, WI 54481

Mailing Address for Claims Appeal:

Reevaluation Committee
Delta Dental of Illinois
P.O. Box 103
Stevens Point, WI 54481

Website Information

Website: www.deltadentalil.me
Online Dentist Directory: www.deltadentalil.me

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DELTA DENTAL®

Section 1: Introduction

In this section, You will find these items:

- Quick overview of Delta Dental of Illinois
- Quick overview of Your Dental Plan
- How to Contact Us

Introduction

About Delta Dental of Illinois

Delta Dental of Illinois is a not-for-profit organization that provides dental plans to groups and individuals in Illinois. Our goal is to improve oral health by making dental care more affordable. Good oral health is important to good overall health. Your Individual Platinum Plan helps You visit the ***Dentist*** regularly and have a healthy smile. Delta Dental of Illinois is a member of Delta Dental Plans Association, the largest and most experienced ***Dental Benefits*** system in the country.

About Your *Dental Plan*

Thank you for choosing Delta Dental of Illinois. We are pleased to provide ***Dental Benefits*** for You and Your family

This dental plan is only available in Illinois. All terms and conditions of this dental plan are ruled by Illinois laws that apply to dental insurance. All ***Dental Benefits*** are paid according to the terms and conditions of this dental plan. Please see Section 5, How Your Dental Plan Works, for more information on the what all is included with Your dental plan.

Please read this booklet carefully and completely. Please refer to this booklet if You have questions on Your dental plan. The dental booklet, including the application and any amendments, endorsements, or riders, constitutes the entire contract between Us and You.

To help make this booklet easier to understand, We use the words "You" and "Your" to refer to you and your family members eligible for coverage under this dental plan. "We, Us and Our" refer to Delta Dental of Illinois. Each word in this booklet that is *italicized* or capitalized has a particular definition. The definitions apply to this booklet and your dental plan. Each word with a definition is defined in Section 6, Definitions.

We encourage You to read Your dental benefit booklet to get the most out of Your dental coverage. The more You understand Your dental coverage, the more You will know what dental services are covered and what You may owe Your ***Dentist***.

Contacting Us

Delta Dental of Illinois' contact information is listed at the beginning of this booklet. Many questions about Your dental plan can be answered faster on Our website at www.deltadentalil.me. Our automated phone system is also available 24 hours a day, seven days a week. A phone with a keypad is needed for Our automated phone system. You can check claims, get plan information, find a network ***Dentist*** and more on Our website or automated phone system.

You also may contact Us at 1-855-335-8267 to speak to customer service. They can answer Your questions about who is covered under Your plan, benefits, claims or general information. Our customer service team is available Monday through Friday, 8 a.m. to 5 p.m., Central Time. You can e-mail customer service at customerservice@deltadentalil.me as well.

DELTA DENTAL®

Section 2: Who Can Be Covered Under This Dental Plan?

In this section, You will find these items:

- Overview of Who the Plan will be Under
- Overview of Who Can be Covered
- Overview of Coverage in the Military

Who Can Be Covered Under This Dental Plan?

Who is the primary member under this dental plan?

The primary member for this dental plan is the person who completed the application or signed up for the dental plan online. This dental plan is only available to people who live in Illinois. All terms and conditions of this dental plan are ruled by Illinois laws that apply to dental insurance. All ***Dental Benefits*** are paid according to the terms and conditions of this dental plan.

Important Notice About Your Application For Your Dental Plan. If your application is not complete or has an error, please let Us know. If Your answers are incorrect or untrue, We may deny coverage or cancel Your dental plan.

Who can be covered under your plan?

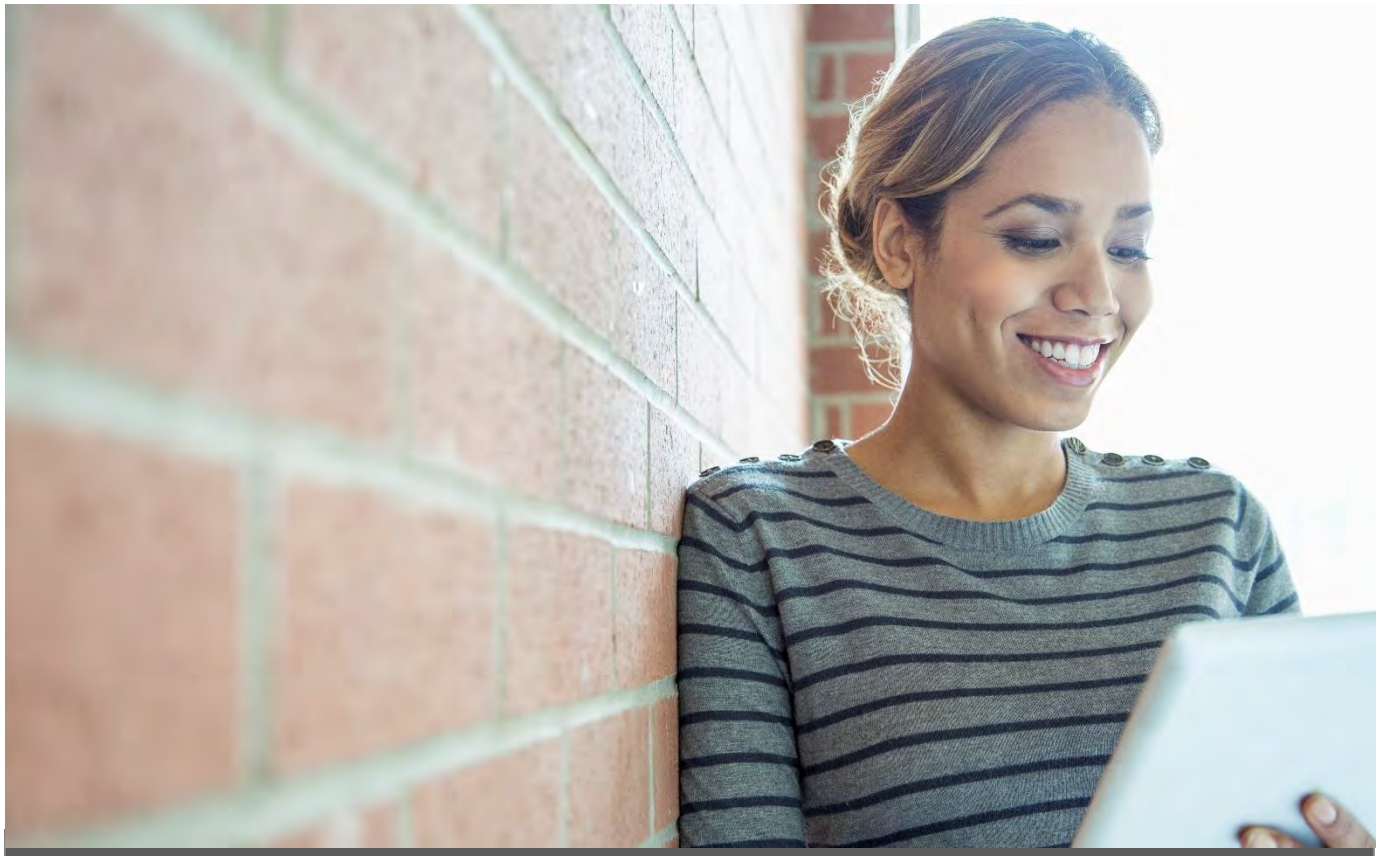
If You signed up for *Family Coverage*, the following family members*, or* ***Dependents****,* may also be covered under this dental plan:

- Your spouse, ***Civil Union Partner*** or ***Domestic Partner***
- Your children to age twenty six (26) or the children of Your spouse, ***Civil Union Partner*** or ***Domestic Partner***, including newborn children, stepchildren, persons by a court order, foster children, legally adopted children , children placed for adoption with You by state or federal law.

How your plan covers members of the military?

If the person who signed up for this dental plan is called for active duty in the military, his/her coverage will end on the date of departure for active duty. If family members are covered under the dental plan, their coverage will continue. When the individual returns to civilian status from active duty, their dental plan may be reinstated if other family members continued coverage on their dental plan. The dental plan will be reinstated on the date active military status ends. If the individual returning to civilian status from active duty did not have family members on their plan, they must reapply for coverage.

Dependents in military service are not eligible for coverage. If Your ***Dependent***, while enrolled under Your dental plan, is called to active duty, coverage for that ***Dependent*** will end on the date of departure for active duty. When Your ***Dependent*** returns to civilian status from active duty, their coverage will be reinstated on the date active military status ends if Your dental plan is still in effect.



Section 3: When Does Your Dental Plan Begin and End

In this section, You will find these items:

- Overview of When Your Plan Begins
- Overview of Adding Family Members
- Overview of What Would Cancel Your Plan

When Does Your Dental Plan Begin and End?

When does Your dental plan start and when can You go to the *Dentist*?

The individual who applied for this dental plan, also known as the ***Policyholder***, will receive coverage as follows:

- Your dental plan will begin after Your application is approved and We receive payment for Your dental plan. You can choose to pay for Your dental plan monthly, semi-annually or annually. If We receive a paper application and credit/debit card payment by the last day of the month, Your dental plan will begin the first day of the following month. If You sign up and pay with a credit/debit card for Your dental plan online by the last day of the month, Your dental plan will begin the first day of the following month. **Applications received on or after the 25th of the month must use a credit/debit card if requesting a first of the following month effective date. If EFT payment is selected, your effective date will be adjusted to the first of the next month.** For example, if We receive an application and EFT payment on March 26, then Your dental plan will begin on May 1. After Your dental plan begins, You can visit a ***Dentist*** for treatment. The date Your dental coverage begins is also known as Your effective date.

Family members, or ***Dependents***, on this dental plan will begin to receive coverage as follows:

- On the date Your coverage begins; or
- On the anniversary of Your effective date. You can add family members to Your dental plan prior to your dental plan renewing for another year. If You add family members to Your dental plan at this time, their coverage begins on Your anniversary date. Your family member is also eligible to join Your dental plan due to one of these events: birth, adoption, placement for foster care, stepchildren gained from a marriage, ***Civil Union*** *or* ***Domestic Partnership*** and children required to be covered by court order a marriage , ***Civil Union*** or ***Domestic Partnership***; or
- Within 30 days of the date a family member, or ***Dependent***, loses coverage from a different dental plan.

Please note that We won't cover some services for You or Your family members outlined in Your dental plan until You or they meet a certain waiting period. There is no waiting period for preventive services, such as cleanings, exams and X-rays, but a waiting period may apply for basic services, like fillings, or major services, like crowns. Any required waiting periods are outlined in this booklet.

How do You add family members, or *Dependents*, to Your dental plan?

If You do not add Your family members, or ***Dependents,*** when they are first eligible, You will need to wait until Your dental plan renews for another year to add them to Your dental plan.

- If You have a new family member, or ***Dependent,*** due to marriage, ***Civil Union*** or ***Domestic Partnership***, the dental plan will begin on the first of the month following the event if Delta Dental of Illinois receives a

status change form. You must complete and send Us a written request within thirty-one (31) days from the date of the event. If there is a change in the cost of Your dental plan, it will be included in the first bill or charge You receive after the change. The amount charged may be adjusted back to the when the change or event took place.

- If You have a new family member, or ***Dependent,*** due to birth, adoption, placement for foster care or placement for adoption, the dental plan for the new family member, *or* ***Dependent***, will begin on the date of birth, adoption, placement for foster care or placement for adoption. You must complete and send a Delta Dental of Illinois a written request within thirty-one (31) days of the event. If there is a change in the cost of Your dental plan, it will be included in the first bill or charge You receive after the change. The amount charged may be adjusted back to when the change or event took place.
- If a court orders that You cover a family member under Your dental plan, the dental plan will begin on the date of the court order after Delta Dental of Illinois receives the written request. The written request must be submitted within thirty-one (31) days after the court order is issued.

If You need to add a family member to Your dental plan because of one of the events shown above, You can submit a request in writing by completing the Contact Us form on the website, logging onto My Account on the website, fax 800-807-1970, or mail to the general mailing address listed on the Contract Information page.

How long will You be covered by Your dental plan?

This dental plan is for 12 months from the date Your coverage began, or effective date. You can choose to end or continue Your dental plan on the anniversary of Your effective date. Your dental plan will automatically continue on the anniversary of Your effective date unless You cancel Your dental plan.

What would cause Your dental plan to end?

Your dental plan, as well as coverage for any family members, or ***Dependents***, on Your plan, will end on the last day of the month, or as noted in ***Dental Plan Specifications,*** after one of the following events:

- You are no longer eligible for a dental plan according to the rules listed in the ***Dental Plan Specifications*** included in this booklet.
- The date You enter active duty in the military;
- Your death
- Date this dental plan is ended by You

Your family members, or ***Dependents,*** will no longer be covered by Your dental plan after one of the following events:

- Your family member, or ***Dependent****, is* no longer eligible for Your dental plan according to the rules listed in ***Dental Plan Specifications***, of this booklet.

- Your spouse is no longer an eligible ***Dependent*** because of a divorce decree or You and Your ***Domestic Partner*** are no longer in a ***Civil Union*** or ***Domestic Partnership*** relationship;
- The last day of the month following the date Your ***Dependent*** child reaches his/her 26th birthday;
- The date Your ***Dependent*** enters active duty in the military;
- Your death
- Date this dental plan is ended by You

Can Delta Dental of Illinois cancel Your dental plan?

Delta Dental of Illinois may cancel Your Dental Plan as follows:

- If You commit fraud or are dishonest on Your application, Your dental plan will end and will be seen as never being in effect. Any payments You made for the dental plan will be refunded except for claims that have already been paid by Delta Dental of Illinois. Delta Dental of Illinois may recover any claim amounts that are more than the total amount paid for the dental plan.
- On the anniversary of Your effective date; or
- If You do not make monthly payments; or
- You have become eligible for a dental plan through Your work, or employer, and We receive a letter in writing at least forty-five (45) days before Your new dental plan will begin; or
- You decide to cancel Your dental plan for any other reason outlined in this booklet, and We receive a letter in writing at least forty-five (45) days before the date You wish to end Your dental plan.

How will Delta Dental of Illinois handle claim payments if my dental plan is cancelled?

Delta Dental of Illinois will only pay claims for services completed by Your ***Dentist*** before Your dental plan ends. Delta Dental of Illinois is not required to pay for any dental services received after the date Your dental plan ends.

Section 4: How Your Dental Plan Works

In this section, You will find these items:

- How to Select a *Dentist*
- Information on *Pre-Treatment Estimates*
- How Claims are Paid

How Your Dental Plan Works

Selecting a *Dentist*

Can You go to any *Dentist?*

Yes. You can go to any licensed ***Dentist*** when You need dental care. Whatever ***Dentist*** You choose, You will receive some level of coverage under Your dental plan. However, You will save money if You visit a ***Dentist*** in one of the Delta Dental networks – the Delta Dental PPO network or the Delta Dental Premier network. You will save the most money if You visit a ***Dentist*** in the Delta Dental PPO network.

Why You should visit a *Dentist* in the Delta Dental PPO network?

- ***Dentists*** in the Delta Dental PPO network agree to accept Delta Dental's PPO fees for services as payment in full. On average, patients save 30 percent on the fee a Delta Dental PPO ***Dentist*** would submit for a claim versus their regular fee. Delta Dental PPO network ***Dentists*** have also agreed not to "balance bill" patients. That means they can't bill You for the difference between the Delta Dental PPO fee and their regular fee.

  Delta Dental Premier® is a safety net for Our Delta Dental PPO network. You will pay more out-of-pocket with a Delta Dental Premier ***Dentist*** compared to a Delta Dental PPO ***Dentist***. However, You may save more money with a Delta Dental Premier ***Dentist*** compared to a non-network ***Dentist***. Delta Dental Premier ***Dentists*** agree to Our ***Maximum Plan Allowances*** as payment in full, which may be lower than the ***Dentist's*** regular fee.

- When You or a covered family member, or ***Dependent,*** visits a network ***Dentist***, the ***Dentist*** submits claims for you. Delta Dental of Illinois pays network ***Dentists*** directly. When You visit a network ***Dentist***, You do not have to pay the whole bill up front. You are only responsible for any ***Deductibles***, co-pays or fees for services not covered by Your dental plan as shown in this booklet.

- If You visit a non-network ***Dentist***, You may have to file Your claim with Delta Dental of Illinois. You may also have to pay Your whole bill upfront at the ***Dentist's*** office before Delta Dental of Illinois sends You a payment. A non-network ***Dentist*** can also "balance bill" You, which means that they can charge You the difference between Delta Dental's fees and the fee they usually charge.

How can You find a network *Dentist*?

We offer two easy ways to find a network ***Dentist*** 24 hours a day, 7 days a week. You can either:

- Search online at www.deltadentalil.me or
- Use the automated phone system by calling 1-855-335-8267.

You can request a list of network ***Dentists*** or specialists within a specific area online or through Our automated phone system. Delta Dental's networks – Delta Dental PPO and Delta Dental Premier - are nationwide. We also recommend that You check with Your ***Dentist*** to see whether he or she is a part of the Delta Dental PPO or Delta Dental Premier network.

Below is an example of how You can save money by visiting a Delta Dental PPO network *Dentist*.

Platinum Plan

	Amount Billed	Delta Dental of Illinois' Allowed Amount	Coverage Percentage Paid by Delta Dental of Illinois	Amount Delta Dental of Illinois Pays*	Amount Dentist Can Bill You Over the Allowed Amount	Total Amount You Pay	Your Total Cost Savings
Procedure 1							
Delta Dental PPO™ Network	$80	$57	100%	$57	$0	$0	$23
Delta Dental Premier® Network	$80	$70	100%	$63	$0	$0	$10
Out-of-Network	$80	$70	100%	$63	$17	$10	$0
Procedure 2							
Delta Dental PPO™ Network	$1,200	$850	60%	$510	$0	$340	$350
Delta Dental Premier® Network	$1,200	$995	50%	$497.50	$0	$497.50	$205
Out-of-Network	$1,200	$995	50%	$497.50	$205	$702.50	$0

*The example chart is relative to plans where Delta Dental Premier network and out-of-network services are paid off of the maximum plan allowance. This information is for illustrative purposes only and assumes the deductible has been met and the annual maximum has not been reached. There are some limitations on the expenses for which your dental plan pays. If you have specific questions regarding benefit coverage, limitations, exclusions or non-covered services, please refer to your policy or certificate of coverage, or contact Delta Dental of Illinois. For specific fees and costs for a certain procedure, you can request a pre-estimate from your dentist.

Delta Dental of Illinois' Payment of Claims

How will You be notified when Delta Dental of Illinois pays or denies a claim?

If You or a covered family member, or ***Dependent,*** submits a claim under this dental plan, and any portion of the claim is denied, You will receive a written notice within 30 days after We receive the claim, unless We need extra time to process the claim due to a special situation. The claim decision will be noted on Your *Explanation of Benefits*. Your ***Explanation of Benefits*** is a notice that shows what We pay and what You may owe Your ***Dentist***. Your ***Explanation of Benefits*** is not a bill.

If You do not owe anything and We pay Your ***Dentist*** *directly*, You may not receive an ***Explanation of Benefits*** because Your claim will have been fully paid. You can still check claim status on Our website or by using Our automated phone system if needed.

Can you choose to have Delta Dental of Illinois pay Your *Dentist* directly instead of yourself?

Delta Dental of Illinois will automatically pay network ***Dentists*** directly for any services You received that are covered by Your dental plan. If You go to a non-network ***Dentist***, You may assign Your benefits to that ***Dentist***. This means that Delta Dental of Illinois will pay Your ***Dentist*** directly for any services You received that are covered by Your dental plan. Please note that if You visit a non-network ***Dentist***, and You do not assign Your benefits to the ***Dentist*** or they do not accept assignment of benefits, Delta Dental of Illinois will pay You directly or You may have to pay the entire bill up front before You are reimbursed by Delta Dental of Illinois.

Are there any limits to claim payments?

Cash will not be paid to You except if You paid Your ***Dentist*** for covered dental services and Delta Dental of Illinois was liable for the payment at the time it was made.

Pre-Treatment Estimates

What is a *Pre-Treatment Estimate*?

A ***Pre-Treatment Estimate*** is a request Your ***Dentist*** sends to Delta Dental of Illinois to find out how much We will pay for a dental service that is covered by Your dental plan before treatment begins. A ***Pre-Treatment Estimate*** gives You and Your ***Dentist*** an idea of how much We will pay Your ***Dentist*** and how much You will owe for a service.

Do You need to submit a *Pre-Treatment Estimate* before You are treated by the *Dentist*?

Pre-Treatment Estimates are not required, but **Delta Dental of Illinois strongly recommends that Your *Dentist* submit a *Pre-Treatment Estimate* for any treatment costing $200 or more.** The ***Pre-Treatment Estimate*** lets You know in advance if the services are covered by Your dental plan. Often patients believe a service is covered if their ***Dentist*** provided it. This is not always the case.

What does a *Pre-Treatment Estimate* need to include?

A ***Pre-Treatment Estimate*** must describe the services that the ***Dentist*** plans to perform, as well as the fees they will charge for each service. We also require Your ***Dentist*** submits the following items so We can estimate what Your dental plan will cover.

Treatment You Are Planning to Receive from the *Dentist*	What We Need from Your *Dentist* for a *Pre-Treatment Estimate*
Periodontics (gum disease treatment)	Full mouth X-rays
Cracked teeth and fixed bridgework	Full arch periapical X-rays
Surgical extractions and cast restorations	Periapical X-rays
Consultations, palliative treatment and general anesthesia	Narrative
Biopsies and surgical removal of tissue	Histopathology and/or hospital report

What happens after a *Pre-Treatment Estimate* request is sent to Delta Dental of Illinois?

We will review the request, along with any required documents sent by Your ***Dentist***. We will issue a ***Pre-Treatment Estimate*** showing how much We will pay for services under Your dental plan. Please keep in mind that a ***Pre-Treatment Estimate*** is only an estimate and not a guarantee of payment. Estimated payment may be less after treatment is completed due to a change in Your or a family member's eligibility, Your ***Deductible*** has been met or renewed, or You exceeded the limit for Your ***Annual Maximum*** by receiving other dental services not included in the ***Pre-Treatment Estimate***. In addition, a ***Pre-Treatment Estimate*** does not consider other dental plans You may have. Delta Dental of Illinois may coordinate benefits with other dental insurance carriers You may have after treatment is complete and a claim is submitted for payment. A ***Pre-Treatment Estimate*** from Delta Dental of Illinois does not limit how Your ***Dentist*** provides treatment. It only relates to how much We will cover under Your dental plan.

Filing a Claim

When do You file a claim?

After You receive services, You should file a claim only if Your ***Dentist*** has not filed one for you. ***Dentists*** in the Delta Dental PPO and Delta Dental Premier networks submit claims for You at no extra cost.

Claims should only be submitted after treatment is finished. Do not submit a claim before treatment is completed.

How do You file a claim?

If Your ***Dentist*** did not submit a claim for you, You can visit Our website at www.deltadentalil.me to download and complete a claim form. Please mail the completed claim for to:

Delta Dental of Illinois
P.O. Box 103
Stevens Point, WI 54481

You must complete and submit a separate claim form for each family member covered by Your dental plan.

What information must be included with a claim?

We require the same documents for a claim that are needed for a ***Pre-Treatment Estimate***. If You did not submit a ***Pre-Treatment Estimate***, please provide the following information from Your ***Dentist***.

Treatment You Received from the *Dentist*	What You Need from Your *Dentist* to Submit a Claim
Periodontics (gum disease treatment)	Full mouth X-rays
Cracked teeth and fixed bridgework	Full arch periapical X-rays
Surgical extractions and cast restorations	Periapical X-rays
Consultations, palliative treatment and general anesthesia	Narrative
Biopsies and surgical removal of tissue	Histopathology and/or hospital report

Is there a deadline to file a dental claim?

Yes, You have one full year from the ***Service Date*** to submit Your dental claims.

Claim Decisions and Appeals

How will You know when Your claim has been processed?

If Your *Dentist* is paid directly: Unless You do not owe anything, You will receive an ***Explanation of Benefits*** that shows what Delta Dental of Illinois will pay for services received and what You may owe Your ***Dentist***. Your ***Dentist*** will receive an Explanation of Payment along with the payment. The Explanation of Payment shows the same information You receive on Your *Explanation of Benefits*.

If You are paid directly: Along with Your payment, You will receive an Explanation of Payment that explains how much Delta Dental of Illinois pays for services received and what You may owe Your ***Dentist***.

You can also check claim status on Our website or through the automated phone system.

Please note: All claim payments and indemnities issued under this dental plan will be paid within 30 days after We receive your claim. If We do not pay a claim within 30 days after we receive it, We will pay You a 9% interest fee per year from the 30th day after We receive your claim to the date we issue the claim payment.

What should You do if Your claim is denied and You don't agree with the decision?

If You or a covered family member has questions about the denial of a claim, please contact Us at 1-855-335-8267. Additional contact information is listed at the beginning of this booklet. We encourage You and covered family members to first talk with Our customer service team to try to fix any issues. If We can't reach a solution, You or Your covered family members have the right to appeal Our claim decision and request that We formally review Your claim.

You may appeal a claim that is denied in writing within 180 days of the date that is on the denial notice. Send Your written request for review to:

Reevaluation Committee
Delta Dental of Illinois
PO Box 103
Stevens Point, WI 54481

You or Your Covered family members should provide the reasons why You disagree with Our claim decision and include any additional documents or records in support of Your appeal. You should include Your name, the covered family member's name, if applicable, and Your member ID number on all documents and records.

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Section 5: Dental Services and Benefits Included with Your Plan

In this section, You will find these items:

- Overview of What's Included and Not Included
- Overview of Plan Limits
- Overview of What You'll Pay Under Your Plan

Dental Services and Benefits Included with Your Plan

What services are included with Your dental plan?

In the Schedule of Benefits of this booklet, You will find a list of the dental services included with Your plan.

What services are not included with Your dental plan?

Not all services that Your ***Dentist*** provides are covered under Your dental plan. See Schedule of Benefits, Exclusions, for a list of services that are not covered under Your dental plan.

Are there any limits to the services included with Your dental plan?

Yes, Delta Dental of Illinois does limit certain benefits and how much We will pay for certain services under Your dental plan. For example, You can only receive a certain number of teeth cleanings a year. Additional teeth cleanings are not covered even if Your ***Dentist*** says that they are necessary. This does not mean that Delta Dental of Illinois believes additional cleanings are unnecessary. Instead, We believe that this is simply a limit on how often We pay for cleanings under Your dental plan. See, ***Schedule of Dental Benefits***, for limits on services provided under Your dental plan.

What is an alternate benefit provision and how does it work?

Sometimes there are many ways to treat a dental issue. Delta Dental of Illinois may only cover one way. This does not mean that Your ***Dentist*** suggested the wrong treatment. In fact, You can apply what We would pay for the covered service toward another form of treatment. But since Delta Dental of Illinois pays the same no matter which treatment You choose; You may pay more out-of-pocket if You choose a treatment that costs more.

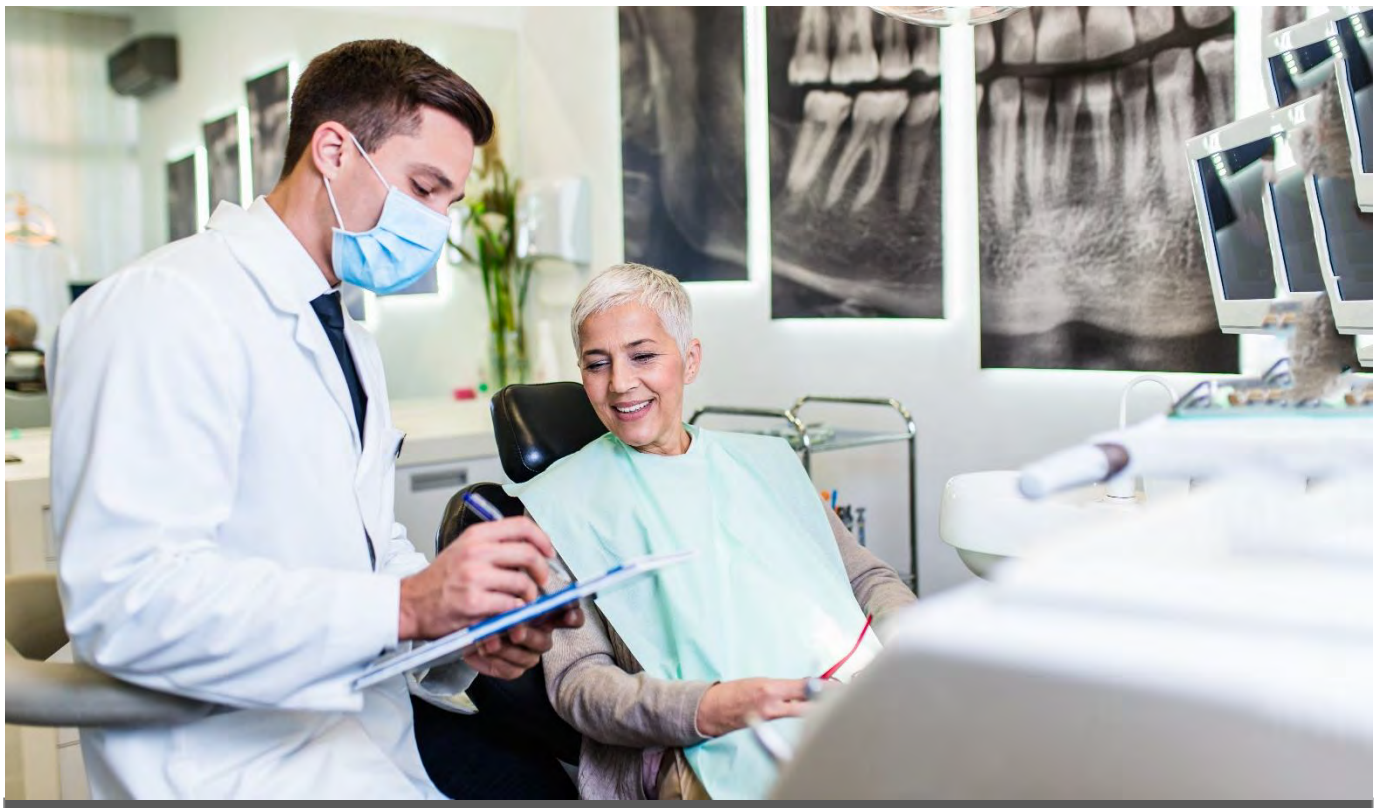
What will You need to pay for with Your dental plan?

Deductible: The amount You pay before Delta Dental of Illinois will begin to help pay for claims. You pay Your ***Deductible*** once a year, based on Your ***Benefit Period***. To view services that require You pay Your ***Deductible,*** see Schedule of Benefits , ***Schedule of Dental Benefits***. For Your ***Deductible*** amount, see Schedule of Benefits, ***Dental Plan Specifications***. A family ***Deductible***, will need to be paid for You and/or any combination of family members before Delta Dental of Illinois will help pay for claims.

Coverage Percentage: The percentage Delta Dental of Illinois will pay for each service included with Your dental plan. This percentage is based on the amount charged by Your ***Dentist*** that is eligible for payment, or ***Allowed Amount***. See Schedule of Benefits, ***Schedule of Dental Benefits*** – for the ***Coverage Percentage*** that Delta Dental of Illinois will pay. If Delta Dental of Illinois' ***Coverage Percentage*** is 80% of the ***Allowed Amount***, You would be responsible for the remaining 20%.

Coverage Limits: The maximum number of times You, or Your covered family members, can receive a specific service in a year, which is based on Your ***Benefit Period***. See Schedule of Benefits, ***Dental Plan Specifications*** – for ***Coverage Limits*** included in Your dental plan.

Lifetime Maximum: The total dollar amount Your dental plan will pay over the course of a lifetime. This may apply to an individual or a family and usually refers to specific treatments such as orthodontia. The ***Lifetime Maximum***, for certain services is shown in Schedule of Benefits, ***Dental Plan Specifications***



Section 6: Definitions

In this section, You will find definitions to words that are used to describe Your dental plan. These words are italicized throughout this booklet. There are also additional terms included in this section that may be on other notices You receive from Us.

Dental Plan Definitions

Allowed Amount - The amount that a network ***Dentist*** agrees to accept as full payment for covered dental services. The ***Allowed Amount*** or ***Scheduled Fee*** is the amount used to determine Your portion of the payment.

Annual Maximum - Your dental plan will pay up to this total dollar amount over a 12-month period.

Benefit Period or ***Benefit Year*** - The amount of time Your dental plan is in effect. Your ***Benefit Period*** is shown in ***Dental Plan Specifications***. Your ***Benefit Period*** determines when You pay Your ***Deductible*** and when You meet certain Waiting Periods. Your ***Benefit Period*** also determines any *Coverage Limits* for each individual on Your dental plan.

Coverage Percentage - The percentage of the ***Allowed Amount*** that is covered by Your dental Plan. The patient pays the remaining ***Coverage Percentage*** after Delta Dental of Illinois pays their share.

Coverage Limits - The maximum number of times You, or Your covered family members, can receive a specific service in a year, which is based on Your ***Benefit Period***.

Covered Individual – The individual who applied for coverage, also known as the ***Policyholder,*** and any family members, or ***Dependents,*** they signed up to receive coverage under their dental plan.

Deductible - The amount You pay before Delta Dental of Illinois will begin to help pay for claims. You pay Your ***Deductible*** once a year, based on Your ***Benefit Period***.

Dental Benefits - Dental services covered under Your dental plan. Your ***Dental Benefits*** depend on the terms and conditions of this booklet.

Dental Plan Specifications - The applicable ***Deductible, Coverage Limits*** and ***Benefit Period*** under Your Dental Plan. The ***Dental Plan Specifications*** are located in this booklet.

Dentist - A doctor who cares for teeth, gums and the mouth. A ***Dentist*** must be licensed to practice dentistry at the time and location services are provided.

Dependent - The ***Policyholder's*** legal spouse, ***Civil Union Partner*** or ***Domestic Partner*** and eligible children (including stepchildren, adopted children, children placed for adoption with the ***Policyholder***, foster children, and children for whom the ***Policyholder*** is a legal guardian). A child living with a ***Covered Individual*** by a court order of adoption is considered an adopted child. For age limits and other eligibility rules for ***Dependent*** children, see ***Dental Plan Specifications***.

Civil Union Partner or ***Domestic Partner*** - A person with whom You have entered into a ***Civil Union*** or ***Domestic Partnership***, which is a legal relationship like marriage. A ***Civil Union*** *or Domestic Partnership* allows both same sex and different sex couples to have a legal relationship with the same responsibilities, protections and benefits that Illinois law provides to married spouses.

Domestic Partnership or Civil Union - A long-term committed relationship with a person that meets the following criteria:

- You and Your ***Domestic Partner*** have lived together for at least 12 months;
- Neither You nor Your ***Domestic Partner*** is married to anyone else or has another ***Domestic Partner***;
- Your ***Domestic Partner*** is at least 18 years of age;
- Your ***Domestic Partner*** lives with You and intends to do so indefinitely;
- You and Your ***Domestic Partner*** have an exclusive mutual commitment that is intended to be permanent;
- You and Your ***Domestic Partner*** are jointly responsible for each other's common welfare and share financial obligations;
- You and Your ***Domestic Partner*** are not related to a degree of closeness that would prohibit legal marriage between opposite or same sex partners.

Explanation of Benefits – The notice You receive from Delta Dental of Illinois that shows how much Delta Dental of Illinois will pay for covered services and how much You may owe Your ***Dentist***. Please note that the ***Explanation of Benefits*** is not a bill. If You do not owe Your ***Dentist*** anything, You may not receive an ***Explanation of Benefits*** from Delta Dental of Illinois.

Family Coverage - Coverage for a ***Policyholder*** plus a spouse, ***Civil Union Partner*** or ***Domestic Partner*** and/or one or more ***Dependent*** children.

Scheduled Fee - The amount a ***Dentist*** in the Delta Dental PPO network agrees to accept as full payment for covered services. The *Fee Schedule* for covered services is given to ***Dentists*** who participate in the Delta Dental PPO network.

Lifetime Maximum - The total dollar amount Your dental plan will pay over the course of a lifetime. This may apply to an individual or a family and usually refers to specific treatments such as orthodontia.

Maximum Plan Allowance - The amount a Delta Dental Premier ***Dentist*** agrees to accept as full payment for covered services. The ***Maximum Plan Allowance*** is shown as the ***Allowed Amount*** on the ***Explanation of Benefits*** if You visit a Delta Dental Premier ***Dentist***.

Policy - The contract between You and Delta Dental of Illinois after You sign up for a dental plan. Your ***Policy*** is outlined in this booklet and includes all the rules regarding services covered under Your dental plan.

Policyholder - The person who applied for coverage under this dental plan, and their application has been accepted by Delta Dental of Illinois. The ***Policyholder*** must make regular payments on their dental plan for it to stay active.

Pre-Treatment Estimate - A ***Pre-Treatment Estimate*** is a request Your ***Dentist*** sends to Delta Dental of Illinois to find out how much We will pay for a dental service that is covered by Your dental plan before treatment begins. A ***Pre-Treatment Estimate*** gives You and Your ***Dentist*** an idea of how much We will pay Your ***Dentist*** and how much You will owe for a service.

Schedule of Dental Benefits - The ***Dental Benefits*** covered under Your plan. See ***Schedule of Dental Benefits***.

Service Date - The date the ***Dentist*** completes a covered dental service. The ***Service Date*** is used to pay claims.

For more dental terms, go to www.deltadentalil.com and select Dental Glossary under Resources.

Section 7: Dental Plan Details

In this section, You will find these items:

- Exclusions (Services Not Covered Under Your Plan)
- *Dental Plan Specifications* (Dates, *Deductibles* and Other Details for Your Plan)

EXCLUSIONS

EXCLUSIONS THAT APPLY TO DIAGNOSTIC SERVICES:

- Pulp vitality tests billed in conjunction with any service except for an emergency exam or palliative treatment are not a covered benefit.

EXCLUSIONS THAT APPLY TO PREVENTIVE SERVICES:

- Recementation of a space maintainer within six months of initial placement is not a covered benefit.

EXCLUSIONS THAT APPLY TO RESTORATIVE SERVICES:

- Fillings are not a covered benefit when crowns are allowed for the same teeth.

- Replacement of any existing cast restoration (crowns, onlays, ceramic restorations) with any type of cast restoration within 60 months following initial placement of existing restoration is not a covered benefit.

- Replacement of a stainless steel crown with any type of cast restoration is not a covered benefit by the same office within 24 months following initial placement.

- A cast restoration is a covered benefit only in the presence of radiographic evidence of decay or missing tooth structure. Restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a covered benefit.

- When there is radiographic evidence of sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration, a crown build-up is not a covered benefit.

- The repair of any component of a cast restoration is not a covered benefit.

- Recementation of inlays, onlays, partial coverage restorations, cast and prefabricated posts and cores and crowns by the same office within six months of initial placement is not a covered benefit.

- Additional procedures to construct a new crown under the existing partial denture framework within six months following initial placement is not a covered benefit.

- When a sedative filling is requested or placed on the same date as a permanent filling, the sedative filling is not a covered benefit.

EXCLUSIONS THAT APPLY TO ENDODONTIC SERVICES:

- When a benefit has been issued for endodontic services, retreatment of the same tooth within two years is not a covered benefit.

- Endodontic procedures performed in conjunction with complete removable prosthodontic appliances are not a covered benefit.

EXCLUSIONS THAT APPLY TO PERIODONTIC SERVICES:

- Guided tissue regeneration billed in conjunction with implantology, ridge augmentation/sinus lift, extractions or periradicular surgery/apicoectomy is not a covered benefit.

- Crown lengthening or gingivoplasty, if not performed at least four weeks prior to crown preparation, is not a covered benefit.

- Bone replacement grafts performed in conjunction with extractions or implants are not a covered benefit.

- Periodontal splinting to restore occlusion is not a covered benefit.

EXCLUSIONS THAT APPLY TO PROSTHODONTIC SERVICES:

- Replacement of any existing prosthodontic appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontic appliance within 60 months following initial placement of existing appliance is not a covered benefit.

- When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the fixed partial denture is not a covered benefit.

- Reline or rebase of an existing appliance within six months following initial placement is not a covered benefit.

- Fixed or removable prosthodontics for a patient under age 16 is not a covered benefit.

- Tissue conditioning is not a covered benefit.

- When the edentulous (toothless) space between teeth is less than 50% of the size of the missing tooth, a pontic is not a covered benefit.

EXCLUSIONS THAT APPLY TO ORAL SURGERY:

- Mobilization of an erupted or malpositioned tooth to aid eruption or placement of a device to facilitate eruption of an impacted tooth performed in conjunction with other oral surgery is not a covered benefit.

GENERAL EXCLUSIONS THAT APPLY TO ALL PROCEDURES:

Coverage is NOT provided for:

- Services compensable under Worker's Compensation or Employer's Liability laws.

- Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.

- Services performed to correct developmental malformation including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and congenitally missing teeth. This exclusion does not apply to *newborn infants.*

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- Charges for services completed prior to the date the person became covered under this ***Policy***.

- Services for anesthetists or anesthesiologists.

- Temporary procedures.

- Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.

- Services performed on non-functional teeth (second or third molar without an opposing tooth).

- Services performed on deciduous (primary) teeth near exfoliation.

- Drugs or the administration of drugs, except for general anesthesia.

- Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.

- Services with respect to any disturbance of the temporomandibular joint (jaw joint).

- Procedures that Delta Dental of Illinois considers to be included in the fees for other procedures. For such procedures, a separate payment will not be made by this dental plan. A ***Dentist*** in the Delta Dental PPO or Delta Dental Premier network may not bill the patient for such procedures.

- The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.

- Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OSHA) requirements.

- Broken appointments.

- Services and supplies for any illness or injury occurring on or after the ***Covered Individual's*** effective date of coverage as a result of war or an act of war.

- Services for, or in connection with, an intentional self-inflicted injury or illness while sane or insane, except when due to domestic violence or a medical (including both physical and mental) health condition.

- Services and supplies received from either a ***Covered Individual's*** or ***Covered Individual's*** spouse's/***Civil Union Partner/Domestic Partner's*** relative, any individual who ordinarily resides in the ***Covered Individual's*** home or any such similar person.

- Services for, or in connection with, an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.

- Charges for services for inpatient/outpatient hospitalization.

- Services or supplies for oral hygiene or plaque control programs.

- Services or supplies to correct harmful habits.

DENTAL PLAN SPECIFICATIONS

ELIGIBILITY REQUIREMENTS

The ***Policyholder*** must be a permanent resident of Illinois.

DEPENDENT CHILDREN

"***Dependent*** children" means those children who are:

- under the age of 26, regardless of their place of residence, marital status or student status; or
- unmarried children age 26 up to the age of 30, if they are Illinois residents, served as a member of the U.S. Armed Forces (active or reserve), and have received a release or discharge other than dishonorable. Submission of proof of military service (U.S. Government Form DD214, Certificate of Release or Discharge from Active Duty) is required.

Coverage for ***Dependent*** children terminates the last day of the month following the date Your Dependent child reaches the limiting age.

Dependent children shall also include children of any age who are and continue to be permanently and totally disabled because of a medically determinable physical or mental impairment, where the disability commenced prior to losing ***Dependent*** status as provided above.

DEDUCTIBLE:

For procedures and services listed in the ***Schedule of Dental Benefits*** that require a ***Deductible***, the ***Covered Individual*** will need to pay a $50 ***Deductible*** per ***Benefit Period*** before Delta Dental of Illinois will pay for claims ***when services are received from a Delta Dental PPO dentist***.

For procedures and services listed in the ***Schedule of Dental Benefits*** that require a ***Deductible***, the ***Covered Individual*** will need to pay a $75 ***Deductible*** per ***Benefit Period*** before Delta Dental of Illinois will pay for claims ***when services are received from a Delta Dental Premier dentist***.

For procedures and services listed in the Schedule of Dental ***Benefits*** that require a ***Deductible***, the ***Covered Individual*** will need to pay a $100 ***Deductible*** per ***Benefit Period*** before Delta Dental of Illinois will pay for claims ***when services are received from a non-network dentist***.

BENEFIT WAITING PERIOD:

Major services listed in the ***Schedule of Dental Benefits*** are covered only after an individual has been enrolled in this individual dental plan for 6 consecutive months.

COVERAGE LIMITS:

IF SAME ***ANNUAL MAXIMUM*** *FOR ALL CATEGORIES OF* ***DENTISTS****:*

The maximum coverage limit (excluding orthodontic benefits) per ***Covered Individual*** per ***Benefit Period*** is $1500.

ENHANCED BENEFITS PROGRAM:

Procedures listed in the ***Schedule of Dental Benefits*** with a single asterisk (*) are part of the Enhanced Benefits Program. Coverage will be at the contracted benefit level, with the additional frequency allowance being the only change. There is no age requirement and the patient may be the Subscriber, or other covered ***Dependents***.

Those eligible for the Enhanced Benefits Program include the following:

- People with periodontal (gum) disease
- People with diabetes
- Pregnant women
- People with high-risk cardiac conditions
- People with kidney failure or who are undergoing dialysis
- People undergoing cancer-related chemotherapy and/or radiation
- People with suppressed immune systems due to HIV positive status, organ transplant, and/or stem cell (bone marrow) transplant

If one of these conditions applies to you, sign up for enhanced benefits today by visiting the Subscriber section of www.deltadentalil.me or calling 1-855-335-8267.

PAYMENT OF PREMIUM

Premiums are to be paid electronically using Your checking/savings account or credit card. If You select as Your method of payment checking/savings account, then Your first premium is to be paid by check. Premiums due for the payment period selected in Your application – annually, or monthly - will be drawn or charged on the 27th of the month of the premium due date. If the premium due amount is dishonored by Your bank or credit card, subsequent payment of any premium due will not keep the ***Policy*** in force, except as provided in the grace period. If any premium due is not received by Us before or at the end of the grace period, the ***Policy*** will automatically end at the end of the period for which the last premium payment has been paid.

GRACE PERIOD

After payment of the first premium, should Your premium due amount be dishonored by the bank or credit card, You will have a grace period of thirty-one (31) days following the premium due date to pay the premium due. Charges incurred during the grace period are not covered unless the premium due is paid by the end of the grace period.

REINSTATEMENT OF *POLICY*

If You default in making any payment under this ***Policy***, the subsequent acceptance of a premium payment by Delta Dental of Illinois or by one of its duly authorized agents shall reinstate the ***Policy***, but with respect to disease and injury may cover only such disease or injury as may be first manifested more than ten days after the date of such acceptance.

SCHEDULE OF DENTAL BENEFITS

The ***Schedule of Dental Benefits*** shows what dental services are covered under Your plan. The words used for dental services in the ***Schedule of Dental Benefits*** is what Your ***Dentist*** would list on the claim he/she sends to Delta Dental of Illinois. If You are unsure of what the below services may be, You can visit Our website at www.deltadentalil.com and select Our Dental Term Glossary under Resources. You can also search for different services and procedures after logging in to the My Account on Our website.

	Co-Payment Percentage			*Deductible* Applies		
Procedure	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	100%	100%	100%	YES	YES	YES
Comprehensive oral evaluation – new or established patient: *once per* ***Dentist***.	100%	100%	100%	YES	YES	YES
Detailed and extensive oral evaluation – problem focused, by report: *once per* ***Dentist***.	100%	100%	100%	YES	YES	YES
Comprehensive periodontal evaluation – new or established patient: *once per* ***Dentist***.	100%	100%	100%	YES	YES	YES
Periodic oral evaluations: *twice per* ***Benefit Year***	100%	100%	100%	YES	YES	YES
Intra-oral – periapical radiographs	100%	100%	100%	YES	YES	YES
Bitewing x-rays (not including vertical bitewings): *twice per* ***Benefit Year***	100%	100%	100%	YES	YES	YES
Complete full mouth x-rays: *once in a 60-month interval. Limited to members over age 6. A full mouth x-ray includes bitewing x-rays. Panoramic x-ray in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total Approved Amount equals or exceeds the Approved Amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 60-month interval.*	100%	100%	100%	YES	YES	YES
Diagnostic casts: *when rendered more than 30 days prior to definitive treatment.*	100%	100%	100%	YES	YES	YES
Pulp vitality tests: *once per visit*	100%	100%	100%	YES	YES	YES

Procedure	Co-Payment Percentage			*Deductible* Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network
Consultations	100%	100%	100%	YES	YES	YES

*If additional detailed or comprehensive oral evaluations are billed by the same **Dentist**, the level of benefits will be limited to that of a periodic oral evaluation.*
Detailed or comprehensive oral evaluations count toward the ***Benefit Year*** maximum of two oral evaluations.

PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): *three per **Benefit Year****	100%	100%	100%	YES	YES	YES
Topical fluoride applications: *three per **Benefit Year***	100%	100%	100%	YES	YES	YES
Interim caries arresting medicament application: *twice per tooth per benefit year*	100%	100%	100%	YES	YES	YES
Space maintainers: *once per lifetime for **Dependent** children under age 14.*	100%	100%	100%	YES	YES	YES
Recementation of space maintainers: *once per* lifetime	100%	100%	100%	YES	YES	YES
Sealants: *applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for **Dependent** children under age 16*	100%	100%	100%	YES	YES	YES
Palliative (emergency) treatment of dental pain - minor procedure	100%	100%	100%	YES	YES	YES

With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance per **Benefit Year.*
With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per **Benefit Year and for topical application of fluoride at the frequency stated in this **Schedule of Dental Benefits**.*
With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per **Benefit Year and for topical application of fluoride at the frequency stated in this **Schedule of Dental Benefits**.*
**With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.*

	Co-Payment Percentage			*Deductible* Applies		
Procedure	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**
RESTORATIVE SERVICES						
Amalgam and anterior resin-based composite fillings *once per surface in a 12-month interval*.	80%	70%	50%	YES	YES	YES
Onlays (permanent teeth only)	60%	50%	50%	YES	YES	YES
Crowns and ceramic restorations (permanent teeth only)	60%	50%	50%	YES	YES	YES
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns	60%	50%	50%	YES	YES	YES
Prefabricated stainless steel crowns	60%	50%	50%	YES	YES	YES
Sedative filling	60%	50%	50%	YES	YES	YES
Pin retention	60%	50%	50%	YES	YES	YES
Cast or prefabricated post and core; core build-up	60%	50%	50%	YES	YES	YES
Additional procedures to construct new crown under existing partial denture framework	60%	50%	50%	YES	YES	YES

When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling.
When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.
Sedative fillings are a covered Dental Benefit once per tooth per lifetime.

	Co-Payment Percentage			*Deductible* Applies		
Procedure	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**
ENDODONTIC SERVICES						
Pulpal and root canal therapy	60%	50%	50%	YES	YES	YES

When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.

Retreatment of root canal therapy within 24 months of initial treatment is not a covered benefit.

When incomplete endodontic therapy is billed because the patient has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pulpal debridement.

Pulpal therapy (resorbable filling) is a covered Dental Benefit once per tooth per lifetime.

	Co-Payment Percentage			*Deductible* Applies		
Procedure	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**
SURGICAL PERIODONTIC SERVICES						
Gingivectomy or gingivoplasty; gingival flap procedure	60%	50%	50%	YES	YES	YES
Clinical crown lengthening - hard tissue	60%	50%	50%	YES	YES	YES
Osseous surgery (including flap entry and closure)	60%	50%	50%	YES	YES	YES
Guided tissue regeneration, per site: *only when performed in association with natural teeth*	60%	50%	50%	YES	YES	YES
Bone replacement and soft tissue grafts	60%	50%	50%	YES	YES	YES
NON-SURGICAL PERIODONTIC SERVICES						
Periodontal scaling and root planning	60%	50%	50%	YES	YES	YES
Full mouth debridement to enable comprehensive evaluation and diagnosis: *once per lifetime*	60%	50%	50%	YES	YES	YES
Periodontal maintenance: *twice per* ***Benefit Year****	60%	50%	50%	YES	YES	YES

Periodontal therapy includes treatment for diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.

With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per* ***Benefit Year**.*
With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per* ***Benefit Year* *and for topical application of fluoride at the frequency stated in this* ***Schedule of Dental Benefits****.*
With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per* ***Benefit Year* *and for topical application of fluoride at the frequency stated in this* ***Schedule of Dental Benefits****.*
**With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.*

	Co-Payment Percentage			*Deductible* Applies		
Procedure	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**
REMOVABLE PROSTHODONTIC SERVICES						
Complete and partial dentures	60%	50%	50%	YES	YES	YES
Adjustments to complete and partial dentures	60%	50%	50%	YES	YES	YES
Repairs to complete and partial dentures	60%	50%	50%	YES	YES	YES
Replace missing or broken teeth	60%	50%	50%	YES	YES	YES
Add tooth or clasp to existing partial denture	60%	50%	50%	YES	YES	YES
Replace all teeth and acrylic on cast metal framework	60%	50%	50%	YES	YES	YES
Denture rebase: *once in a 24-month interval.*	60%	50%	50%	YES	YES	YES
Denture reline: *once in a 24-month interval.*	60%	50%	50%	YES	YES	YES

Procedure	Co-Payment Percentage			*Deductible* Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network
FIXED PROSTHODONTIC SERVICES (BRIDGES)						
Pontics	60%	50%	50%	YES	YES	YES
Fixed partial denture retainers - inlays/onlays (inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures)	60%	50%	50%	YES	YES	YES
Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures)	60%	50%	50%	YES	YES	YES
Recement fixed partial denture	60%	50%	50%	YES	YES	YES
Cast or prefabricated post and core; core build-up	60%	50%	50%	YES	YES	YES

When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 60 months following placement of the initial appliance is not a covered benefit.

When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of one pontic per missing tooth.

When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.

If, in the construction of a prosthodontic appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontic appliance.

When a porcelain/ceramic inlay is requested or placed as an abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.

Procedure	Co-Payment Percentage			*Deductible* Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network
ORAL SURGERY						
Simple extractions	60%	50%	50%	YES	YES	YES
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	60%	50%	50%	YES	YES	YES
Removal of impacted tooth – soft tissue	60%	50%	50%	YES	YES	YES
Removal of impacted tooth – partially bony	60%	50%	50%	YES	YES	YES
Removal of impacted tooth – completely bony	60%	50%	50%	YES	YES	YES
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus	60%	50%	50%	YES	YES	YES
Surgical access of an unerupted tooth	60%	50%	50%	YES	YES	YES
Biopsy of oral tissue; brush biopsy	60%	50%	50%	YES	YES	YES
Alveoloplasty - per quadrant	60%	50%	50%	YES	YES	YES
Vestibuloplasty - ridge extension	60%	50%	50%	YES	YES	YES
Surgical excision of soft tissue lesions	60%	50%	50%	YES	YES	YES
Surgical excision of intra-osseous lesions	60%	50%	50%	YES	YES	YES
Other covered surgical/repair procedures: Removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess - intraoral soft tissue; frenulectomy or frenuloplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	60%	50%	50%	YES	YES	YES

Oral Surgery includes extractions and other listed oral surgery procedures (including pre- and post-operative care) only when provided in a ***Dentist's*** *office.*

Procedure	Co-Payment Percentage			*Deductible* Applies		
	Delta Dental PPO	**Delta Dental Premier**	**Out-of-network**	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**
ADJUNCTIVE GENERAL SERVICES						
Palliative (emergency) treatment of dental pain - minor procedure	100%	100%	100%	YES	YES	YES
Deep sedation/general anesthesia: *when provided by a **Dentist** in conjunction with Oral Surgery (surgical procedures) other than simple extractions.*	60%	50%	50%	YES	YES	YES
Intravenous conscious sedation/analgesia: *when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.*	60%	50%	50%	YES	YES	YES
Athletic mouthguard, *once every 24-months for dependent children under age 19*	60%	50%	50%	YES	YES	YES
OTHER MAJOR SERVICES						
Implants *once every 7-years*	60%	50%	50%	YES	YES	YES
Teeth whitening *when supervised by a dentist*	60%	50%	50%	YES	YES	YES

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

Problems with Your Insurance? — If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Delta Dental of Illinois
P.O. Box 103
Stevens Point, WI 54481
(855) 335-8267

You can also contact the ILLINOIS DEPARTMENT OF INSURANCE, a state agency which enforces Illinois' insurance laws, and file a complaint. You can contact the ILLINOIS DEPARTMENT OF INSURANCE at:

Illinois Department of Insurance
Consumer Complaints
320 West Washington St.
Springfield, IL 62767
(866) 445-5364
(217) 557-6955

DELTA DENTAL

Discrimination is Against the Law

Delta Dental of Illinois complies with all applicable Federal and State civil rights laws. Delta Dental of Illinois does not discriminate, exclude people, or treat them differently on the basis of gender, sex (which includes discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity or expression; and sex stereotypes), race, color, religious creed, national origin, citizenship, age, physical or intellectual disability, protected veteran status, marital status, genetic information, or any other characteristic protected by law.

Delta Dental of Illinois:

- Provides free auxiliary aids and services to individuals with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, braille, audio, accessible electronic formats, etc.)
- Provides free language assistance services to people whose primary language is not English, such as:
  - Qualified interpreters for oral interpretation
  - Electronic and written translated documents in other languages

If you need these services, contact our Civil Rights Coordinator.
If you believe that Delta Dental of Illinois has failed to provide these services or discriminated in any way, you can file a grievance with:

Civil Rights Coordinator
Delta Dental of Illinois
111 Shuman Boulevard
Naperville IL 60563
Phone: 630-718-4807
Email: compliance@deltadentalil.com

You can file a grievance in person or by mail, phone or email. If you need help filing a grievance, our Civil Rights Coordinator 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://hhs.gov/ocr/office/file/index.html
This notice is available at Delta Dental of Illinois' website at https://www.deltadentalil.com/non-discrimination-notice/

العربية **(Arabic)**	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على ال 1-800-323-1743 أو تحدث إلى مقدم الخدمة.
繁體中文 (Chinese)	注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-323-1743 或與您的提供者討論。
Français (French)	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-323-1743 ou parlez à votre fournisseur.
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-323-1743 an oder sprechen Sie mit Ihrem Provider.
Ελληνικά (Greek)	ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-800-323-1743 ή απευθυνθείτε στον πάροχό σας.
ગુજરાતી **(Gujarati)**	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-323-1743 પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी (Hindi)	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-323-1743 पर कॉल करें या अपने प्रदाता से बात करें।
Italiano (Italian)	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-323-1743 o parla con il tuo fornitore.
한국어 (Korean)	주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-323-1743 번으로 전화하거나 서비스 제공업체에 문의하십시오.
Polski (Polish)	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-323-1743 lub porozmawiaj ze swoim dostawcą.
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-323-1743 или обратитесь к своему поставщику услуг.
Español (Spanish)	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-323-1743 o hable con su proveedor.
Tagalog (Tagalog – Filipino)	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-323-1743 o makipag-usap sa iyong provider.
اُردُو (Urdu)	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-800-323-1743 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Tiếng Việt (Vietnamese)	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-323-1743 hoặc trao đổi với người cung cấp dịch vụ của bạn.