Your Dental Policy

From Delta Dental of New Jersey, Inc.

Delta Dental Individual- Preventive Family PPO Plan

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

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



DELTA DENTAL

WELCOME

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

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

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

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

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

POLICY RENEWAL AND SUBSCRIPTION CHARGES

You may keep this **Policy** in force by timely payment of **Subscription Charges**. But, **Delta Dental** may not renew this **Policy** on the following basis:

1. Non-payment of **Subscription Charges**. There is a grace period of thirty (30) days (ninety (90) days if **You** are getting a **Premium Subsidy** for this **Policy)** as noted in Section 4.3, or
2. Fraud or material misrepresentation made by or with the knowledge of a **Covered Person** applying for this **Policy** or making a **Claim** for **Benefits** under this **Policy**, or
3. A **Covered Person** engaging in intentional non-compliance with material rules of this **Policy**, or
4. Sending any **Claim** to **Delta Dental** which has a knowing misstatement of fact, or
5. **Delta Dental** ceasing to renew all **Policies** issued on this form to residents of New Jersey.

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

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

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

By: _____
Vice President, Underwriting & Actuarial Services

Dental Program Overview

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

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

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

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

Because **We** apply the **Coverage Percent** to the **Allowed Amount**, and because there are **Benefit Limitations** and **Exclusions** and **Alternate Treatment Limitations** that may apply to the **Dental Service** that **You** receive, **We** may pay no **Benefit** toward a **Covered Service** or, pay a **Benefit** that is less than the **Coverage Percent** of the **Approved Amount**. **You** should read the detail in Sections 7.0 and 8.0. As **We** note in Section 10.1, for **Covered Services** which do not already require **Prior Authorization**, **We** urge **You** to ask for a **Pre-Treatment Estimate** for **Dental Services** which cost more than $300. But **You** can also ask for one for **Dental Services** that cost less than that.

SUMMARY RELATING TO PEDIATRIC ENROLLEES	
Summary of Covered Services **(IMPORTANT NOTE - - This is only a summary. Section 7.0 lists the Covered Services as well as the Specific Limitations and Specific Exclusions that apply to each Covered Service. And, Section 8 lists the General Exclusions that apply under this Policy. Network Dentists are described in Section 1.2.1.)**	**Coverage Percent of the Allowed Amount Paid by Delta Dental***
Preventive and Diagnostic **Dental Services** to check existing dental health and to prevent dental disease, such as exams, cleanings, and x-rays.	100%
Basic Restorative **Dental Services** to fix or repair teeth harmed by decay or fracture, such as amalgam and composite fillings.	50%
Crowns Repair of teeth with crowns when they cannot be restored with other filling materials.	50%
Endodontics The care of teeth with damaged nerves, such as root canal treatment.	50%
Periodontics The treatment of diseases of the gums and supporting bone, such as scaling and root planing.	50%
Fixed and Removable Prosthodontics **Dental Services** and appliances to replace missing teeth, such as dentures and bridges (excluding implants).	50%
Implants Implant Services for edentulous (missing all natural teeth) **Pediatric Enrollees** (otherwise implants are not covered).	50%
Adjunctive General Services **Dental Services** include consultations, general anesthesia, and palliative care (temporary treatment of dental pain).	50%
Oral Surgery Tooth extractions and other dental surgery.	50%
Medically Necessary Orthodontic Services	50%
Coverage Period Deductible (applied to Preventive and Diagnostic Services)	$135 **per Pediatric Enrollee** $405 for all **Pediatric Enrollees**
Coverage Period Maximum Cost Share Limit (applies for services from PPO dentists only)	$350 per **Pediatric Enrollee** $700 per two (2) or more **Pediatric Enrollees**

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

SUMMARY RELATING TO ADULT ENROLLEES	
Summary of Covered Services **(IMPORTANT NOTE - - This is only a summary. 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 that apply under this Policy. Network Dentists are described in Section 1.2.1)**	**Coverage Percent of the Allowed Amount Paid by Delta Dental***
Preventive and Diagnostic **Dental Services** to check existing dental health and to prevent dental disease, such as exams, cleanings, and x-rays.	100%
Basic Restorative **Dental Services** to fix or repair teeth harmed by decay or fracture, such as amalgam and composite fillings.	Not Covered
Crowns Repair of teeth with crowns when they cannot be restored with other filling materials.	Not Covered
Endodontics The care of teeth with damaged nerves, such as root canal treatment.	Not Covered
Periodontics The treatment of diseases of the gums and supporting bone, such as scaling and root planing.	Not Covered
Fixed and Removable Prosthodontics **Dental Services** and appliances to replace missing teeth, such as dentures and bridges (excluding implants).	Not Covered
Oral Surgery Tooth extractions and other dental surgery.	Not Covered
Adjunctive General Services **Dental Services** include consultations, general anesthesia, and palliative care (temporary treatment of dental pain).	Not Covered
Coverage Period Deductible when services are rendered by a **Network Dentist** (not applied to Preventive and Diagnostic Services)	None
Coverage Period Deductible when services are rendered by a **non-Network Dentist** (applied to Preventive and Diagnostic Services)	$75 **per Adult Enrollee**
Coverage Period Annual Maximum when services are rendered by a **Network Dentist**	Unlimited
Coverage Period Annual Maximum when services are rendered by a **non-Network Dentist**	$500

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

Table of Contents

Page

1.0 – USING THIS DENTAL PROGRAM

1.1 - About Delta Dental

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

1.2.1 Network Dentists in New Jersey

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

1.2.2 Non-Network Dentists

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

1.3 Locating a Network Dentist

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

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

By calling, **You** can get a customized list of **Network Dentists**, both **Delta Dental PPO℠ Dentists** and **Delta Dental Participating Specialists** within the area of **Your** request. **Delta Dental** mails the list to **Your** home. By searching on **Our** Website, **You** can get a customized list of **Network Dentists** in a specific town. The list can be downloaded right away. **You** can search for as many towns as needed. Using either method, **You** can get listings of general **Dentists** only or specialists only. **You** can get **Network Dentist** information for any of the 50 states should you need a **Dentist** when **You** travel outside of New Jersey.

1.4 Selecting a Network Dentist

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

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

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

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

1.5 Your First Dental Visit

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

If **Your Dentist** plans to perform a **Dental Service** for a **Pediatric Enrollee** that requires **Prior Authorization**, **You** or **Your Dentist** must take the steps set out in Sections 10 and 12. Where **Prior Authorization** is required but not obtained, **We** can apply a penalty of up to 50% of the charges that would otherwise be covered.

If **Your Dentist** submits a proposed treatment plan to **Delta Dental**, **Delta Dental** will supply a **Pre-Treatment Estimate** for **Services.** A **Pre-Treatment Estimate** is available for **Dental Services** for **adult Enrollees** and also for **Pediatric Enrollees** even for **Dental Services** for which **Prior Authorization** is not required. This will let **You** and **Your Dentist** find out how much of the charge **You** owe. Before treatment is started, be sure **You** talk with **Your Dentist** about the total amount of his or her fee. **Delta Dental** suggests **You** ask **Your Dentist** to send a request for **Pre-Treatment Estimate** for treatment costing $300 or more even if **Prior Authorization** for required services rendered to **Pediatric Enrollees** is not required. Keep in mind that **Pre-Treatment Estimates** are only estimates and not promises or guarantees of payment.

1.6 Contacting Delta Dental

On the Web

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

By Phone

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

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

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

By Mail

Wyssta Services, Inc.
P.O. Box 103
Stevens Point, WI 54481-0103

(**Policy** service is provided by Wyssta Services, Inc.)

2.0 – POLICY DEFINITIONS

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

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

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

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

5. "**Annual Period**" means each **Calendar Year**.

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

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

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

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

10. "**Benefit Maximum**" means the total dollar limit that **Delta Dental** will pay toward **Covered Services** for each **Adult Enrollee** during a **Coverage Period**. See Section 6.4.

11. "**Benefited As**" refers to when a **Dental Service** is performed or pre-estimated for an **Adult Enrollee**, but the **Benefit Amount** is based on a different **Dental Service** or category of **Dental Service**. When this happens, all the **Benefit Limitations** and **Exclusions** apply to the **Dental Service** for which **Delta Dental** pays the **Benefit**.

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

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

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

15. "**Claim**" is a request to **Delta Dental** to pay a **Benefit** under this **Policy**.

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

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

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

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

20. "**Cost Share**" means the total amount **a Covered Person** pays out of his or her own pocket per **Calendar Year** for **Covered Services** completed by **Network Dentists** on a **Pediatric Enrollee** during the **Coverage Period**.

21. "**Cost Share Limit**" means the maximu**m a**mount of **Cost Share** that a **Covered Person** must pay **per Calendar Year** before **Delta Dental** pays 100% of the **Allowed Amount** for **Covered Services** completed by **Network Dentists** on **Pediatric Enrollees**.

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

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

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

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

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

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

28. "**Deductible**" means the specified dollar amount that a **Covered Person** is required to pay toward a **Covered Service** each **Calendar Year** before **Delta Dental** will pay any **Benefit** toward the **Covered Service**. That dollar amount is specified in Section 7.0 of this **Policy**.

29. "**Definitive Procedure**" means any **Dental Service** which has been given a Current Dental Terminology (CDT) procedure code. **Definitive Procedures** may be combined for payment

purposes. That a **Dental Service** has been assigned a CDT procedure code does not mean it is a **Covered Service**.

30. "**Delta Dental**" means Delta Dental of New Jersey, Inc.

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

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

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

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

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

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

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

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

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

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

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

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

43. **"General Exclusion(s)" means the Exclusions** listed in Section 8**.**0**.**

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

45. "**Medically Necessary Orthodontic Services**" means **Comprehensive Orthodontic Treatment** that meets the criteria for "**Dental Necessity**" as defined in this policy and also meets at least one of the following criteria:
    a. The **Pediatric Enrollee's** condition necessitates a core of 26 or more points on a correctly scored modified Salzmann Malocclusion Severity Assessment; or
    b. The **Pediatric Enrollee** demonstrates that the requested treatment will significantly ameliorate a mental, emotional, or behavioral condition associated with the **Pediatric Enrollee's** dental condition; or

c. The **Pediatric Enrollee** presents evidence demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, or facial trauma resulting in severe functional difficulties.

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

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

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

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

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

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

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

52. **"Pediatric Enrollee"** means a **Subscriber** and each other person who is eligible and enrolled for coverage under this **Policy** who is less than age nineteen (19) at the **Policy Anniversary Date**. It includes the **Subscriber's Spouse**, a former **Spouse** for whom the **Subscriber** is legally liable to provide dental coverage, a **Civil Union** or **Domestic Partner**, a biological child, stepchild, foster child, legally adopted child, child of the **Subscriber's** civil union or domestic partner, and children under a court appointed guardianship who are less than age nineteen (19) at the **Policy Anniversary Date**. The **Pediatric Enrollee** is the person who (a) is listed on the application that is a part of this **Policy**; (b) has been accepted by **Delta Dental** as a **Pediatric Enrollee**; and (c) for

whom the proper **Subscription Charges** have been paid in full. A person shall no longer be a **Pediatric Enrollee** under this **Policy** at the point when such person is age 19 or over at the most recent **Policy Anniversary Date**, or otherwise stops meeting the definition of **Pediatric Enrollee**, or as of the **Coverage Expiration Date**. Persons in military services are not eligible to be **Pediatric Enrollees** under this **Policy**.

53. "**Policy**" means this document.

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

55. "**PPO Approved Fee**" means the fee approved by **Delta Dental** or by **Another Delta Dental Plan** for **Dental Services** rendered by **Delta Dental PPO^{SM} Dentists** in the respective state. It can be changed from time to time by **Delta Dental** or by **Another Delta Dental Plan**.

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

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

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

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

60. "**Schedule of Benefits" is** a listing of the specific **Covered Services** and **Benefit Limitations** and **Exclusions** for **Dental Services** provided under this **Policy**. The **Schedule of Benefits** is contained in Section 7.0 of this Policy. **General Exclusions** are listed in Section 8.0.

61. "**Specific Exclusions**" mean the Specific Exclusions listed in Section 7.0 as applicable to the **Dental Service**.

62. "**Specific Limitations**" mean the Specific Limitations listed in Section 7.0 as applicable to the **Dental Service**.

63. "**Spouse**" means the **Subscriber's** lawful **Spouse**, the **Subscriber's Civil Union Partner**, or the **Subscriber's Domestic Partner**.

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

65. "**Subscription Charges**" means the total monthly premium due for this **Policy**.

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

67. "**We**," "**Us**," and "**Our**" means Delta Dental of New Jersey, Inc.

68. "**You**" or "**Your**" means the **Subscriber**.

3.0 – ELIGIBILITY AND ENROLLMENT

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

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

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

3.1 – Pediatric Enrollees

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

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

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

3.2 – Adult Enrollees

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

1. be listed on the application that is part of this **Policy**;
2. have been accepted by **Delta Dental** for coverage;
3. have paid in full the **Subscription Charges** due; be age 19 but under age 27; or;
4. A disabled child of the **Subscriber, Spouse, Domestic Partner or Civil Union Partner** over the age of 26 who is not capable of self-sustaining employment. This must be due to a developmental disability or physical handicap. **Your** child must be dependent upon **You** or **Your Spouse** for total or partial support.

A doctor's statement certifying a child as disabled must be submitted to **Delta Dental** within 31 days of **Your** child's 27th birthday. After that, **Delta Dental** may need **You** to resubmit proof of **Your** child's continuing eligibility. A disabled child is eligible for coverage until any one of the following events happens:

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

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

c) **You** do not keep paying **Your Subscription Charges**;

d) **Delta Dental** ends this **Policy**.

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

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

3.3 – Continued Coverage for Other Family Members of the Subscriber
A **Covered Person** who is a **Family** member of the **Subscriber** may choose to keep his or her coverage under this **Policy** as a **Subscriber** with his or her own **Policy** if:

1. The **Subscriber** dies;

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

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

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

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

1. marriage (including entry into a **Civil Union** or domestic partnership);
2. divorce or legal separation (including termination of **Civil Union** or domestic partnership);
3. birth or adoption of a child;

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

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

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

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

3.5 - The Coverage Period

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

Eligibility for other **Covered Family** members of a **Subscriber** ends:

1. at the end of the month for a **Spouse**, when the **Subscriber** and **Spouse** divorce (unless coverage is provided subject to a court order);

2. at the end of the month for a **Civil Union Partner** or **Domestic Partner**, when the **Civil Union** or domestic partnership is terminated (unless coverage is provided subject to a court order);

3. when a child covered as an **Adult Enrollee** reaches his or her 27th birthday;

4. for disabled children, the last day of the year when the disabled child covered as an **Adult Enrollee** is no longer physically or mentally incapacitated as described in Section 3.2; or

5. for all **Family** members who are **Covered Persons**, the last day of the month when the **Subscriber** becomes deceased.

Fraudulent Information
If a **Covered Person** gives false or misleading information to defraud **Delta Dental**, this **Policy** becomes null and void. **We** shall tell the proper state and regulatory authorities. This includes, but is not limited to, the Office of the Insurance Fraud Prosecutor (OIFP). It is a crime to give false, incomplete, or misleading information on purpose to defraud **Delta Dental**. Penalties include imprisonment, fine, and denial of **Benefits**.

4.0 – SUBSCRIPTION CHARGES, POLICY RENEWAL, AND TERMINATION

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

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

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

If **You** are getting a **Premium Subsidy** for this **Policy**, **You** have a grace period of ninety (90) days past the due date to pay **Your Subscription Charges**. If **You** do not make payment, **Delta Dental** will end this **Policy**. Your **Policy** stays in force during the grace period. We will pay **Benefits** under this **Policy** only for **Dental Services** completed during the first thirty (30) days of the grace period unless and until **You** have paid **Us** all the charges due through the date of payment.

4.4 - Non-Payment of Subscription Charges and Reinstatement
Your Policy ends if **You** have not paid the full amount of the **Subscription Charges** due by the end of the grace period. If this occurs, **You** cannot reapply for coverage for twenty-four (24) months from the date **Your Policy** ended. After 24 months, **We** will need a new application. The Effective Date of **Your** new coverage will be the date of **Our** approval.

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

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

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

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

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

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

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

4.8 – Termination of this Policy
Termination by **You**

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

For **You**

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

For **Your** covered **Spouse, Civil Union or Domestic Partner**

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

For **Your** covered child (**Pediatric Enrollees** under age 19 and **Adult Enrollees** age 19 and over)

1. **Your** covered child becomes covered under a group dental plan offered by an employer;
2. **Your** covered child dies;
3. **Your** covered child enters military service;
4. **Your** covered child's marital status changes;
5. At the time of **Your Policy** renewal.

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

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

Termination by **Delta Dental**
We may terminate this **Policy** during the **Coverage Period** only for the following reasons:

1. **You** fail to pay **Subscription Charges** when due or within the grace period;
2. A **Covered Person** commits fraud or makes an intentional misrepresentation of a material fact, as determined by **Us**;
3. A **Covered Person** lets a person not covered under this **Policy** use the I.D. card of anyone covered under this **Policy**;
4. A **Covered Person** fails to follow the terms of this **Policy** as determined by **Us**.

We will give **You** notice of termination and the reason for termination. Except for numbers 1 and 2 above, **We** will give **You** notice at least thirty (30) days prior to the last date of coverage.

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

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

5.0 – CHOOSING A DENTIST

5.1 Payment for **Covered Services** rendered to **Covered Persons** by **Delta Dental PPO^{SM} Dentists** shall be as follows:

(a) Delta Dental's Benefit Amount

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

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

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

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

(c) Total Charge for Covered Service

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

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

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

(a) Delta Dental's Benefit Amount

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

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

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

(b) Covered Person's Payment

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

(c) Total Charge for Covered Service

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

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

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

(a) Delta Dental's Benefit Amount

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

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

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

(b) Covered Person's Payment

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

(c) Total Charge for Covered Service

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

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

(a) Delta Dental's Benefit Amount

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

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

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

(b) Covered Person's Payment

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

(c) Total Charge for Covered Service

The **Non-Participating Dentist** will collect the entire fee he or she has charged for the **Dental Services** performed.

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

Examples for Pediatric Enrollees

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

EXAMPLE FOR PEDIATRIC ENROLLEES			
	Network Dentists		**Non-Network Dentists**
Dentist Type & Network	**Delta Dental PPO℠ Dentist (Delta Dental PPO SM network)**	**Delta Dental Participating Specialists (New Jersey only)**	**Dentists who are neither Delta Dental PPO℠ Dentists nor Delta Dental Participating Specialists**
Description	**You** will be responsible for the difference between **Delta Dental's Benefit Amount** and the least of the **Delta Dental PPO℠ Dentist's** actual fee, the fee the **Dentist** has filed with **Us** or **Another Delta Dental Plan**, or the **PPO Approved Fee** for the **Dental Service** performed.	**You** will be responsible for the difference between **Delta Dental's Benefit Amount** and the least of the **Dentist's** actual fee, the fee filed with **Delta Dental**, or the **Delta Dental Participating Specialist's Maximum Approved Charge** for the **Dental Service** performed.	**You** will be responsible for the difference between **Delta Dental's Benefit Amount** and the **Dentist's** actual fee for the **Dental Service** performed. **Delta Dentals' Benefit Amount** is based on the lesser of the **Dentist's** actual fee or the **PPO Approved Fee**.
Example*	**Delta Dental PPO SM Dentist**	**Delta Dental Participating Specialists (New Jersey only)**	**Non-Network Dentists**
Dentist Charge for **Dental Services**	$1,000	$1,000	$1,000
Approved Amount for **Dental Services**	$640	$800	$640
Allowed Amount for **Dental Services**	$640	$800	$640
Coverage Percent	60%	60%	60%
Delta Dental Payment	$384	$480	$384
Pediatric Enrollee's Payment	$640 - $384 **= $256**	$800 - $480 = **$320**	$1,000 - $384 = **$616**

The following examples with 3 **Dental Services** show how **Deductibles** would affect the amount **You** must pay. **Note: Your Deductible** and **Coverage Percent** also apply to **Emergency Dental Services**.

The **Benefit** will be the amount (if any) **We** would have paid under this **Policy** if the **Dentist** were a **Delta Dental PPO[SM] Dentist.**

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

Examples for Adult Enrollees

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

EXAMPLE FOR ADULT ENROLLEES			
	Network Dentists		**Non-Network Dentists**
Dentist Type & Network	**Delta Dental PPO℠ Dentist (Delta Dental PPO SM network)**	**Delta Dental Participating Specialists** (New Jersey only)	**Dentists who are neither Delta Dental PPO℠ Dentists, nor Delta Dental Participating Specialists**
Description	**You** will be responsible for the difference between **Delta Dental's Benefit Amount** and the least of the **Delta Dental PPO℠ Dentist's** actual fee, the fee the **Dentist** has filed with **Us** or **Another Delta Dental Plan**, or the **PPO Approved Fee** for the **Dental Service** performed.	**You** will be responsible for the difference between **Delta Dental's Benefit Amount** and the least of the **Dentist's** actual fee, the fee filed with **Delta Dental**, or the **Delta Dental Participating Specialist's Maximum Approved Charge** for the **Dental Service** performed.	**You** will be responsible for the difference between **Delta Dental's Benefit Amount** and the **Dentist's** actual fee for the service performed. **Delta Dental's Benefit Amount** is based on the lesser of the **Dentist's** actual fee, the fee filed with **Delta Dental**, or the **PPO Approved Fee**.
Example*	**Delta Dental PPO SM Dentist**	**Delta Dental Participating Specialists (New Jersey only)**	**Non-Network Dentists**
Dentist Charge for **Dental Services**	$1,000	$1,000	$1,000
Approved Amount for **Dental Services**	$640	$800	$1,000
Allowed Amount for **Dental Services**	$640	$800	$700
Coverage Percent	60%	60%	60%
Delta Dental Payment	$384	$480	$420
Adult Enrollee's Payment	$640 - $384 **= $256**	$800 - $480 = **$320**	$1,000 - $420 = **$580**

The following examples with 3 **Dental Services** show how **Deductibles** and **Benefit Maximums** would affect the amount **You** must pay.

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

6.0 – POLICY COVERAGE TERMS

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

6.1 - Deductibles

The annual **Deductible** for **Covered Services** is: (a) $135 for each **Pediatric Enrollee**; (b) $405 for all **Pediatric Enrollees**; (c) $0 for each **Adult Enrollee**; when services are rendered by a **Network Dentist**; and (d) $75 for each **Adult Enrollee** when services are rendered by a **non**-**Network Dentist**; Once a **Covered Person** has paid the annual **Deductible**, no additional **Deductible** is required to be paid for **Covered Services** during that year.

6.2 – Cost Share Limit (Applicable only to Pediatric Enrollees)

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

6.3 - Coverage Percent and Coinsurance Percent

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

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

6.4 – Benefit Limitations and Exclusions

This **Policy** does not cover every aspect of dental care and every **Dental Service** recommended or performed by a **Dentist**. This **Policy** provides payment only toward **Covered Services**. **Covered Services** are subject to **Benefit Limitations** and **Exclusions** listed in Section 7.0 and 8.0.
When Section 7.0 states that "no **Benefit** will be paid for a **Dental Service**," the **Covered Person** is responsible for paying the **Dentist** the full **Approved Amount** for that **Dental Service**.

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

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

6.6 – **Benefit Maximums (Applicable to Adult Enrollees)**
The maximum Calendar Year **Benefit** payment for each **Adult Enrollee** is unlimited for **Dental Services** rendered by a **Network Dentist** and $500 for **Dental Services** rendered by an **Out-of-Network Dentist**].

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

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

7.1 – DENTAL SERVICES RENDERED TO PEDIATRIC ENROLLEES

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

7.1 Diagnostic

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

Specific Limitations

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

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

Deductible	Coverage Percent Paid By Delta Dental	Covered Services
7.1.2 Yes	100%	Intraoral complete mouth series (CMX) and panoramic x-rays

Specific Limitations

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

Deductible	Coverage Percent Paid By Delta Dental	Covered Services
7.1.3 Yes	100%	Intraoral radiographs (periapicals)

Specific Limitations

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

Deductible	Coverage Percent Paid By Delta Dental	Covered Services
7.1.4 Yes	100%	Bitewing x-rays

Specific Limitations

None.

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

Specific Limitations

A) None.

Deductible	Coverage Percent Paid By Delta Dental	Covered Services
7.1.6 Yes	100%	Pulp vitality test diagnostic casts for diagnostic purposes only and not in conjunction with other services

Specific Limitations

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

7.1 Diagnostic Necessary **Dental Services** to assist the **Dentist** in evaluating the existing oral condition to determine required dental treatment.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.1.7 Yes	100%	Oral pathology laboratory – accession/collection of tissue, examination-gross and microscopic, preparation and transmission of written report, accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report, other oral pathology procedures by report.
Specific Limitations A) None		

Diagnostic Services **Specific Exclusions**
7.1.8 The following **Specific Exclusions** apply to diagnostic services. **Specific Exclusions** A) Any diagnostic service not listed as a **Covered Service** is **Excluded**. The following are also specifically **Excluded**: Pre-diagnostic cancer screening tests

7.2 Preventive Services Necessary **Dental Services** to prevent future dental disease.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.2.1 Yes	100%	Prophylaxis (teeth cleaning)
Specific Limitations A) No **Benefit** will be paid for prophylaxis when: (a) any combination of prophylaxes is performed by the same dentist/dental office more than once (1) in a 6-month period, (b) more than once (1) in 3-month period for a **Child with Special Health Care Needs**.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.2.2 Yes	100%	Office applied topical fluoride applications including fluoride varnish (per visit)
Specific Limitations A) No **Benefit** will be paid for topical fluoride treatment by the same dentist/dental office: (a) more than once (1) per 6-month period, (b) when not performed in conjunction with a prophylaxis, or (c) more than once (1) every 3-month period for a **Child with Special Health Care Needs**. B) No **Benefit** will be paid for fluoride varnish (a) more than once (1) per 3-month period for **Pediatric Enrollees** under six (6) years of age.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.2.3 Yes	100%	Application of sealants
Specific Limitations A) No **Benefit** will be paid for sealants when applied to any tooth surface other than the occlusal surface of premolars and permanent molars which are free of restorations (including sealants, preventive resin restorations placed on the occlusal surface of the same tooth on the same day).		

7.2 Preventive Services Necessary **Dental Services** to prevent future dental disease.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.2.4 Yes	100%	Space maintainers to maintain space for eruption of permanent tooth/teeth (includes placement and removal), fixed unilateral and bilateral, removable bilateral only, recementation of fixed space maintainer, removal of space maintainer (for provider that did not place the appliance).

Specific Limitations

A) No **Benefit** will be paid for space maintainers for missing permanent teeth.

B) No **Benefit** will be paid for unilateral removable space maintainer.

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

Specific Exclusions

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

1. Procedures such as nutritional and tobacco counseling, oral hygiene instructions, risk assessment, and counseling.
2. Fluoride gels, rinses, tablets, or other preparations meant for home application.
3. Removal of space maintainers by the **Same Dentist** who placed the appliance.
4. Procedures mainly for plaque control.
5. Preventive resin restorations.

7.3 Basic Restorative Services **Dental Services** for the restoration of teeth due to dental caries (decay) or fracture primarily using silver amalgam or composite resin materials as fillings after the decay is removed.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.3.1 Yes	50%	• Amalgam (silver) fillings • Composite (tooth colored) fillings • Protective restoration/sedative filling • Pin retention

Specific Limitations

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

B) No **Benefit** will be made for more than one procedure code per tooth on the same day except when amalgam and composite restorations are placed on the same tooth.

C) Reimbursement for occlusal restorations includes any extensions onto the occlusal one-third of the buccal or lingual surface(s) of the tooth.

D) Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. An additional surface will be reimbursable only when the buccal (facial) or lingual margin extends beyond the proximal one-third of the buccal (facial) and/or lingual surface(s).

7.3 Basic Restorative Services **Dental Services** for the restoration of teeth due to dental caries (decay) or fracture primarily using silver amalgam or composite resin materials as fillings after the decay is removed.
E) The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.

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

7.4 Restorative – Crowns, Gold Foils, Inlays, and Onlays **Dental Services** directly or indirectly fabricated involving the specified material.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.4.1 Yes	50%	Gold foils, indirectly fabricated single crowns to restore form and function, metallic inlays, onlays, indirectly fabricated (custom fabricated/cast) and prefabricated post and core, additional fabricated (custom fabricated/cast) and prefabricated post, and core build-up (including pins), additional procedures to construct new crown under existing partial denture framework, coping.
Specific Limitations A) Gold foils, inlays, onlays, and crowns include all adjunctive services such as but not limited to local anesthesia, temporary crown placement, insertion with recementation, polishing, impressions, laboratory fees, adjusting occlusion, etc. No separate **Benefit** will be paid for these and/or similar adjunctive services. B) No **Benefit** will be paid for gold foil restorations, inlay and onlay restorations unless they are performed in a teaching institution or residency program. No **Benefit** will be paid for non-metallic inlays and onlays. C) No **Benefit** will be paid for indirectly fabricated crowns and onlays: (a) unless the teeth cannot be restored with other restorative materials, (b) when performed for cosmetic reasons, (c) for teeth that are not in occlusion or function, and (d) for teeth that have a poor long term prognosis. D) No **Benefit** will be paid for gold foils and inlays: (a) when performed for cosmetic reasons, (b) for teeth that are not in occlusion or function, and (c) for teeth that have a poor long term prognosis.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.4.2 Yes	50%	Prefabricated stainless steel, stainless steel crown with resin window, and resin crowns.
Specific Limitations A) Prefabricated stainless steel and resin crowns include all adjunctive services such as but not limited to local anesthesia, insertion with cementation and adjusting occlusion. No separate **Benefit** will be paid for these and/or similar adjunctive services.		

7.4 Restorative – Crowns, Gold Foils, Inlays, and Onlays **Dental Services** directly or indirectly fabricated involving the specified material.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.4.3 Yes	50%	Crown repairs and recementation of crowns, inlays, onlays, post and cores, post removal, temporary crown (fractured tooth).
Specific Limitations A) No **Benefits** will be paid for temporary crowns unless the tooth is fractured and the crown is placed as an immediate protective device.		

Restorative – Crowns, Gold Foils, Inlays, and Onlays Specific Exclusions
7.4.4 The following **Specific Exclusions** apply to restorative – crowns, gold foils, inlays, and onlays: **Specific Exclusions** A) Any restorative procedure not specifically listed as a **Covered Service**. The following are also specifically **Excluded**: 1. Provisional or temporary or interim crowns (except for immediate protection of a fractured tooth) 2. Any procedures, restorations, or appliances associated with periodontal splinting 3. Restorative foundation for indirect restoration 4. Labial veneers B) No **Benefit** will be paid for indirectly fabricated crowns, gold foils, inlays, and onlays: (a) when performed for cosmetic reasons or (b) unless the teeth cannot be restored to form and function with other restorative materials. C) Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.

7.5 Endodontics Necessary **Dental Services** for pulpal therapy and root canal therapy to treat or remove the nerves inside the tooth chamber and roots.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.5.1 Yes	50%	Root canal therapy, pulpal therapy for anterior and posterior primary teeth.
Specific Limitations None.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.5.2 Yes	50%	Pulpotomy and pulpal debridement for primary and permanent teeth, partial pulpotomy for apexogenesis, treatment for root canal obstruction, incomplete therapy (inoperable, unrestorable, or fractured tooth), internal root repair of perforation.
Specific Limitations None.		

7.5 Endodontics Necessary **Dental Services** for pulpal therapy and root canal therapy to treat or remove the nerves inside the tooth chamber and roots.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.5.3 Yes	50%	Apexification/recalcification (initial, interim, and final visits), apicoectomy/periradicular surgery, retrograde fillings, and pulpal regeneration, root amputation, hemisections.
Specific Limitations None.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.5.4 Yes	50%	Retreatment of root canal therapy, post removal, canal preparation and fitting of preformed dowel or post, surgical procedure for isolation of tooth with rubber dam.
Specific Limitations None.		

Endodontics
Specific Exclusions

7.5.5 The following **Specific Exclusions** apply to endodontic services:

Specific Exclusions

A) Any endodontic service not listed as a **Covered Service**. The following are specifically **Excluded**:
   1. Pulp caps
   2. Endodontic endosseous implant
   3. Intentional reimplantation
   4. Temporary restorations and routine postoperative care
   5. Periradicular surgery without apicoectomy
   6. Bone grafts and regenerative procedures in conjunction with periradicular surgery

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

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

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

7.6 Periodontics Necessary procedures to treat diseases of the tissues (gums) and bone supporting the teeth.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.6.1 Yes	50%	Periodontal scaling and root planing, localized delivery of antimicrobial agents.
Specific Limitations A) No **Benefit** will be paid for periodontal scaling and root planing within a 6-month period except for **Children with Special Health Care Needs**.		

7.6 Periodontics Necessary procedures to treat diseases of the tissues (gums) and bone supporting the teeth.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.6.2 Yes	50%	• Periodontal maintenance • Full mouth debridement
Specific Limitations None.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.6.3 Yes	50%	Surgical services, gingivectomy and gingivoplasty, gingival flap including root planing, apically positioned flap, clinical crown lengthening, osseous surgery, bone replacement graft first site and additional sites, biologic materials to aid in soft and osseous tissue regeneration, guided tissue regeneration, surgical revision, pedicle and free soft tissue grafts, subepithelial connective tissue graft, distal or proximal wedge, soft tissue allograft, combined connective tissue and double pedicle graft.
Specific Limitations None.		

Periodontics **Specific Exclusions**
7.6.4 The following **Specific Exclusions** apply to periodontic services: **Specific Exclusions** A) Any periodontal procedure not specifically listed as a **Covered Service**. The following are also specifically **Excluded**: 1. Anatomical crown exposure, provisional splinting, 2. Unscheduled dressing change 3. Laser disinfection and laser assisted new attachment procedures 4. Gingival irrigation 5. Provisional splinting B) Periodontal treatment requires **Prior Authorization**. Where **Prior Authorization** is required but not obtained, **We** can apply a penalty of up to 50% of the charges that would otherwise be covered.

7.7 Prosthodontics – Fixed and Removable **Dental Services** to replace missing permanent teeth (not including third molars) to address masticatory deficiencies (impaired chewing function).		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.7.1 Yes	50%	Removable maxillary and mandibular, complete and immediate complete dentures, resin and cast frame partial dentures (including any conventional clasps, rests, and teeth) to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s), and cuspid(s)), precision attachments, flexible base partial dentures (including any clasps, rests, and teeth), complete and partial overdentures.

7.7 Prosthodontics – Fixed and Removable

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

Specific Limitations

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

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

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

Deductible	Coverage Percent Paid By Delta Dental	Covered Services
7.7.2 Yes	50%	Fixed partial dentures (bridges), including retainers (crowns) pontics, core buildups, and post and cores.

Specific Limitations

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

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

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

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

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

Deductible	Coverage Percent Paid By Delta Dental	Covered Services
7.7.3 Yes	50%	Adjustments, repairs, relines, rebases to removable complete and partial dentures.

Specific Limitations

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

B) No **Benefit** will be paid for denture relines or rebases on the same day or within 12 months after denture insertion.

7.7 Prosthodontics – Fixed and Removable		
Dental Services to replace missing permanent teeth (not including third molars) to address masticatory deficiencies (impaired chewing function).		
C) No **Benefit** will be paid for adjustments on the same day or within 6 months after a reline, rebase, or repair. D) A rebase or reline when performed more than once (1) per 12 months requires **Prior Authorization**. Where **Prior Authorization** is required but not obtained, **We** can apply a penalty of up to 50% of the charges that would otherwise be covered.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.7.4 Yes	50%	Recementation of fixed partial dentures (bridges).
Specific Limitations None.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.7.5 Yes	50%	Repair of fixed partial dentures (bridges).
Specific Limitations None.		

Prosthodontics – Fixed and Removable Specific Exclusions
7.7.6 The following **Specific Exclusions** apply to fixed and removable prosthodontic services: **Specific Exclusions** A) Any fixed or removable prosthodontic procedures not listed as **Covered Services** are **Excluded**. The following are also specifically **Excluded**: 1. Interim complete, partial dentures, and prefabricated dentures 2. Any procedures; restorations; or appliances and/or crown and fixed partial denture associated with periodontal splinting 3. Interim, provisional, or temporary pontics and retainers, connector bars, stress breakers 4. Unilateral removable partial dentures or dentures without clasps 5. Tissue conditioning 6. Non-metallic inlays and onlays 7. Replacement of all teeth and acrylic on cast metal framework for removable partial dentures 8. Inlay and onlay fixed partial denture retainers unless performed in a teaching institution or residency program B) Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.

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

7.8 Maxillofacial Prosthetics		
		medicament carrier, adjustments, modification and repair to a maxillofacial prosthesis, maintenance and cleaning of maxillofacial prosthesis.
Specific Limitations A) No **Benefit** will be paid for adjustments to maxillofacial prosthetics within six months following placement. B) Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.		

7.9 Implants A device designed to be inserted into the jaw bone to replace a missing tooth.		
Deductible	**Coverage Percent Paid By Delta**	**Covered Services**
7.9.1 Yes	50%	Implant body, abutment, and crown.
Specific Limitations None.		

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

7.10 Oral and Maxillofacial Surgical Services Dental Services including the extraction of teeth, as well as minor surgical preparation of the mouth for insertion of dentures.		
Deductible	**Coverage Percent Paid By Delta**	**Covered Services**
7.10.1 Yes	50%	• Extraction of coronal remnants-deciduous tooth, extraction, erupted tooth or exposed root, surgical removal of erupted tooth or residual root, removal of soft tissue impactions • Surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, placement of a device to aid eruption, surgical repositioning of teeth, transeptal/fiberotomy/supra crestal fiberotomy, surgical placement of anchorage device with or without flap.
Specific Limitations A) No **Benefit** will be paid for local anesthesia and suturing (if needed) when performed by the **Same Dentist** on the same day as oral and maxillofacial surgery.		

7.10 Oral and Maxillofacial Surgical Services

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

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

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

Specific Limitations

None.

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

Specific Limitations

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

Oral Surgery
Specific Exclusions

7.10.4 The following **Specific Exclusions** apply to Oral Surgery services:

Specific Exclusions

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

7.11 Medically Necessary Orthodontic Services Services to prevent, intercept, or correct malocclusion (bad bite).		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.11.1 Yes	50%	• All listed services must meet **Medically Necessary Orthodontic Services** criteria • Limited treatment for the primary, transitional and adult dentition • Interceptive treatment for the primary and transitional dentition • Minor treatment to control harmful habits • Comprehensive treatment for handicapping malocclusions of the permanent dentition • Orthodontics associated with orthognatic surgical cases • Repairs for orthodontic appliances • Replacement of lost or broken retainers • Rebonding or recementing of brackets and/or bands • Continuation of transfer cases or cases started outside the program

Specific Limitations

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

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

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

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

1. Orthodontic treatment requires **Prior Authorization** and is not considered for cosmetic purposes.
2. Orthodontic consultation can be provided once annually as needed by the same provider.
3. Pre-orthodontic treatment visit for completion of HLD (NJ-Mod2) assessment form (accessible at www.deltadentalnj.com), diagnostic photographs, diagnostic models, cephalometric radiograph and tracing, description of proposed treatment plan and patient's diagnostic condition, and panoramic radiograph/views are required for consideration of services.
4. Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
5. Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
6. Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
7. The placement of the appliance represents the treatment start date.
8. Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for a **Dentist** that did not start case and requires **Prior Authorization**.
9. Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

7.11 Medically Necessary Orthodontic Services

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

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

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

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

7.12 Adjunctive General Services

Other **Dental Services**.

Deductible	Coverage Percent Paid By Delta Dental	Covered Services
7.12.1 Yes	50%	Palliative treatment

Specific Limitations

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

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

Specific Limitations

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

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

Deductible	Coverage Percent Paid By Delta Dental	Covered Services
7.12.4 Yes	50%	Behavior management

Specific Limitations

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

B) Behavior management for additional time to provide services for **Children with Special Health Care Needs** that requires more time than generally required to provide a dental service and that is accompanied by a request

7.12 Adjunctive General Services		
Other **Dental Services**.		
that indicates a specific medical diagnosis and clinical appearance and exceeds the thresholds in (C) based on place of service requires **Prior Authorization.** Where **Prior Authorization** is required but not obtained, **We** can apply a penalty of up to 50% of the charges that would otherwise be covered. C) One unit equals 15 minutes of additional time: 1. Office or clinic – 2 units 2. Inpatient/outpatient hospital – 4 units Skilled nursing/long term care – 2 units		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.12.5 Yes	50%	Consultations by specialist or non-primary care **Dentists**
Specific Limitations None.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.12.6 Yes	50%	Professional visits – house or facility visit-for a single visit to a facility regardless of the number of members seen on that day, hospital or ambulatory surgical center call-for cases that are treated in a facility, for cases taken to the operating room-dental services are provided for **Pediatric Enrollees** with a medical condition covered by this **Policy** which requires this admission as in-patient or out-patient (**Prior Authorization** is required), general anesthesia and outpatient facility charges for dental services are covered, dental services rendered in these settings by a dentist not on staff are considered separately, office visit for observation (during regular hours)-no other service performed.
Specific Limitations A) No **Benefit** will be paid for more than one (1) house or facility visit regardless of the number of **Pediatric Enrollees** seen that day. B) No **Benefit** will be paid for hospital or ambulatory surgical call for cases that are not treated in such a facility. C) Professional visits – house or facility visit-for a single visit to a facility regardless of the number of members seen on that day, hospital or ambulatory surgical center call-for cases that are treated in a facility, for cases taken to the operating room-dental services are provided for **Pediatric Enrollees** with a medical condition covered by this **Policy** which requires this admission as in-patient or out-patient require **Prior Authorization.** Where **Prior Authorization** is required but not obtained, **We** can apply a penalty of up to 50% of the charges that would otherwise be covered.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.12.7 Yes	50%	Drugs – therapeutic parenteral drug (single administration, two or more administrations-not to be combined with single administration), other drugs and/or medicaments by report
Specific Limitations A) None.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.12.8 Yes	50%	• Application of desensitizing medicament - per visit • Occlusal guard - for treatment of bruxism, clenching or grinding • Athletic mouthguard covered once per year

7.12 Adjunctive General Services Other **Dental Services**.		

		• Occlusal adjustment
		  • Limited - (per visit)
		  • Complete
		• Odontoplasty
		• Internal bleaching

Specific Limitations A) No **Benefit** will be paid for complete occlusal adjustment more than once (1) per lifetime regardless of the number of visits. B) No **Benefit** will be paid for an occlusal guard not performed to treat bruxism, clenching, or grinding. C) No **Benefit** will be paid for more than one athletic mouthguard per 12 month period.		

Adjunctive General Services Specific Exclusions
7.12.9 The following **Specific Exclusions** apply to adjunctive general services: **Specific Exclusions** A) Any adjunctive **Service** not listed as a **Covered Service** is **Excluded**. The following are also specifically **Excluded**: 1. Fixed partial denture sectioning 2. Miscellaneous: reline and adjustment of occlusal guard, occlusal analysis including mounted case, enamel microabrasion, external bleaching Case presentation, office visit after regularly scheduled hours, application of desensitizing resin

7.2– DENTAL SERVICES RENDERED TO ADULT ENROLLEES

7.2 Diagnostic and Preventive Services Necessary **Dental Services** to assist the **Dentist** in evaluating the existing oral condition to determine required dental treatment and **Dental Services** intended to prevent future dental disease.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.2.1 No, in network. Yes, non-network.	100%	Dental evaluations, including comprehensive, routine and emergency evaluations, as well as consultations
Specific Limitations No **Benefit** will be paid for dental evaluations of any type as well as consultations when any mix of these **Dental Services** is performed more than twice (2) in a 12-month period. No allowance will be paid for **Comprehensive** evaluations, performed by the **Same Dentist** within 3 years. Evaluations within 3 years after a **Comprehensive** evaluation by the **Same Dentist** will be **Benefited As** periodic evaluations. A **Comprehensive** periodontal evaluation is **Benefited As** a periodic evaluation when performed by the **Same Dentist** on the same date as periodontal maintenance. No **Benefit** will be paid for separate charges for evaluation of hard and soft tissues of the oral cavity, periodontal charting, oral cancer evaluation and screening, blood pressure screenings, pulse, temperature, respiration, base EKG, treatment planning, evaluation of **Patient's** dental and medical history, general and/or oral health assessments, diagnosis, pulp test (except limited oral evaluations-problem focused) when performed **In**		

7.2 Diagnostic and Preventive Services

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

Conjunction With an oral evaluation, consultation or other professional visit.

Deductible	Coverage Percent Paid By Delta Dental	Covered Services
7.2.2 1 No, in network. Yes, non-network.	100%	Intraoral complete mouth series (CMX) and panoramic x-rays

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.

Deductible	Coverage Percent Paid By Delta Dental	Covered Services
7.2.3 1 No, in network. Yes, non-network.	100%	Intraoral radiographs

Specific Limitations

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

Deductible	Coverage Percent Paid By Delta Dental	Covered Services
7.2.4 1 No, in network. Yes, non-network.	100%	Bitewing x-rays (one set equals one or more bitewing films taken on the same day)

Specific Limitations

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

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

Deductible	Coverage Percent Paid By Delta Dental	Covered Services
7.2.5 1 No, in network. Yes, non-network.	100%	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 emergency conditions. No **Benefit** will be paid for more than one (1) pulp vitality test per visit.

7.2 Diagnostic and Preventive Services Necessary **Dental Services** to assist the **Dentist** in evaluating the existing oral condition to determine required dental treatment and **Dental Services** intended to prevent future dental disease.		
Deductible	**Coverage Percent Paid By Delta Dental**	**Covered Services**
7.2.6 1 No, in network. Yes, non-network.	100%	Prophylaxis (teeth cleaning)

Specific Limitations

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

Diagnostic and Preventive Services
Specific Exclusions & Alternate Treatment Limitations

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

Specific Exclusions

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

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

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

Alternate Treatment Limitations

The **Benefit Amount** for full mouth debridement will be determined based on the **Benefit Amount** for prophylaxis

Diagnostic and Preventive Services Specific Exclusions & Alternate Treatment Limitations
subject to the above **Specific Limitations** and **Specific Exclusions** applicable to prophylaxis. The **Adult Enrollee** is responsible for the difference between the **Benefit Amount** for the prophylaxis and the **Approved Amount** for the **Dental Service** actually rendered. Panoramic x-ray with or without bitewing x-rays performed on the same day is **Benefited As** a complete mouth series of x-rays and subject to the 5-year Frequency Limit. Eight or more periapical x-rays performed on the same day by the **Same Dentist** are **Benefited As** a full mouth series of x-rays and subject to the 5-year Frequency Limit.

8.0 - GENERAL EXCLUSIONS (APPLICABLE TO ALL DENTAL SERVICES)

The reference to a **Dental Service** in this section does not mean that it would otherwise be a **Covered Service**.

8.1 – GENERAL EXCLUSIONS APPLICABLE TO PEDIATRIC ENROLLEES

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

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

    a. **Dental Services** not specifically listed as **Covered Services** in Section 7.0 of this **Policy**, including but not limited to maxillofacial prosthetics.

    b. **Dental Services** that are not **Dentally Necessary**.

    c. **Dental Services** for which a **Claim** was not submitted within twelve (12) months after the date when the **Dental Service** was finished.

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

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

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

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

or community agency, except to the extent such payments are not enough to pay the **Approved Amount** therefor.

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

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

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

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

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

m. Charges for hospitalization.

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

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

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

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

r. Tooth preparation; acid etching; temporary restorations and crowns; bases; direct and indirect pulp caps; polishing; caries removal; microabrasion; endodontic working, final treatment, and follow up radiographs; gingivectomy **In Conjunction With** restorations; impressions; lab fees and material; local anesthesia services in conjunction with operative

or surgical procedures, and other **Dental Services** which **Delta Dental** considers to be part of a more **Comprehensive Dental Service**.

s. Broken appointments.

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

u. Periodontal charting.

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

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

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

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

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

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

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

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

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

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

ff. Myofunctional therapy.

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

hh. **Dental Services** or appliances for cosmetic purposes.

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

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

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

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

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

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

8.2 – GENERAL EXCLUSIONS APPLICABLE TO ADULT ENROLLEES

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

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

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

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

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

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

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

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

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

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

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

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

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

l. Charges for hospitalization, including hospital visits.

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

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

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

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

q. Broken appointments.

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

s. Periodontal charting.

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

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

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

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

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

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

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

aa. Myofunctional therapy.

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

cc. **Dental Services** or appliances for cosmetic purposes.

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

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

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

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

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

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

9.0 – OTHER PAYMENT RULES THAT AFFECT YOUR COVERAGE

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

9.1 – Dental Services Requiring Multiple Visits

9.1.1 - Some **Dental Services** take multiple visits to complete. Examples include crowns, bridges, removable prosthetics, and endodontic procedures. Except for covered **Medically Necessary Orthodontic Services** performed on **Pediatric Enrollees**, **Delta Dental** pays for **Covered Services** that need multiple visits only upon completion of the **Dental Services**. The **Completion Date** is deemed to be the date of service for these **Dental Services**.

9.1.2 - For **Pediatric Enrollees**, Delta **Dental** will first make one payment at the start of covered **Medically Necessary Orthodontic Services** (the initial payment). That payment will be based on 20% of the total **Allowed Amount** for the **Prior Authorized Orthodontic Services**. Medically **Necessary Orthodontic Services** require **Prior Authorization.** Where **Prior Authorization** is required but not obtained, **W**e can apply a penalty of up to 50% of the charges that would otherwise be covered. **Delta Dental** will make quarterly payments for the balance of the **Allowed Amount** for those **Dental Services**. Each quarterly payment will be prorated. For example, if the **Dental Service** plan is for twenty-four (24) months, **Delta Dental** will make quarterly payments of one eighth ($1/8^{th}$) of the balance that remains after the initial payment. Quarterly payments will stop at the earlier of the completion of the **Dental Services** or the date when the **Patient** is no longer a **Pediatric Enrollee**.

9.2 - In-Process Treatment

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

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

9.3 - Incomplete Treatment

One **Dentist** may start a **Dental Service**, and another **Dentist** may finish it. If this happens, **Delta Dental** will pay no **Benefit** for the **Dental Service** performed by the **Dentist** who did not complete the **Dental Service**. **Delta Dental's** payment of a **Benefit** will only be for the **Dental Services** rendered by the **Dentist** who finishes the **Dental Service**.

10.0 - PRIOR AUTHORIZATIONS, PRE-TREATMENT ESTIMATES, CLAIMS, AND APPEALS

10.1 - Pre-Treatment Estimate

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

10.2 - Prior Authorization (Applicable to Pediatric Enrollees)

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

10.3 - Filing a Claim or a Request for Prior-Authorization

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

c/o Wyssta Services, Inc.
P.O. Box 103
Stevens Point, WI 54481-0103

(**Policy** management and service is provided by Wyssta Services, Inc.)

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

10.4 - BENEFITS PAID TO NON-PARTICIPATING DENTISTS

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

10.5 - Claims Review and Appeals Procedures

You have the right to appeal any **Adverse Benefit Determination**.

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

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

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

10.6 - Notice of Adverse Benefit Determination

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

The **Explanation of Benefits** will include the following information:

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

- The relevant scientific or clinical judgment will be included if the **Adverse Benefit Determination** is about medical or dental need, experimental treatment, or other similar exclusion or limitation.

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

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

c/o Wyssta Services, Inc.
P.O. Box 103
Stevens Point, WI 54481-0103

(**Policy** management and service are provided by Wyssta Services, Inc.)

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

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

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

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

c/o Wyssta Services, Inc.
P.O. Box 103
Stevens Point, WI 54481-0103

(**Policy** management and service are provided by Wyssta Services, Inc.)

The request for a formal review must include the following:

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

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

10.9 - Delta Dental's Review

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

10.10 - Notice of Review Decision

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

If **Delta Dental** upholds the **Adverse Benefit Determination** on appeal, the notice will include the following information:

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

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

- A description of **Delta Dental's** informal appeal and formal **Claim** appeal processes and the time limits applicable to the processes.

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

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

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

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

11.0 - GENERAL TERMS AND CONDITIONS

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

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

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

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

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

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

11.7 - Overpayments
Delta Dental has the right to get back any payment made to a **Covered Person** or **Dentist** which is more than the amount the person was entitled to get under this **Policy** or if the
Payment was made to the wrong payee. **Delta Dental** may offset any such overpayment against any amount which otherwise is due under this **Policy**.

11.8 - Notices
Any notice sent to **Delta Dental** shall be sent in writing. Such notice is considered to be delivered when delivery is in person or when sent by registered or certified United States mail return receipt requested, proper postage prepaid, and addressed to:

c/o Wyssta Services, Inc.
P.O. Box 103
Stevens Point, WI 54481-0103

(**Policy** management and service are provided by Wyssta Services, Inc.)

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

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

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

11.12 - Limitation of Liability
All **Dental Services** paid for by **Delta Dental** shall be in accordance with the accepted dental practices in the community at the time. **Delta Dental** shall not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice by any officer or employee or by any **Dentist** or others engaged by him while rendering **Dental Services** to any **Covered Person**, but this Section 11.12 shall not in any way absolve **Delta Dental** from any liability imposed upon it by N.J.S.A 2A: 53A-33. In no case shall any **Dentist** whom **You** consult for treatment or who renders treatment to **You** or **a Covered Person** be deemed an agent or employee of **Delta Dental**.

11.13 - Compliance with Laws and Regulations
Any provision of this **Policy** which does not comply with all pertinent federal and state laws and rules, including, but not limited to, the applicable health care privacy and disclosure provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) shall be unenforceable and the remaining terms shall constitute the **Policy**. If this **Policy**, or any part of it, is found not to be in compliance with any pertinent federal or state law or rule, then **Delta Dental** shall administer this **Policy** in accordance with federal or state law or rule and change the **Policy** to correct the noncompliance.

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

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.

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

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

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

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

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

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

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

APPENDIX A to SECTION 12.0
SERVICES REQUIRING PRIOR AUTHORIZATION
Applicable to **Pediatric Enrollees**

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

1. Sealant replacement.

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

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

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

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

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

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

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

9. Behavior management when exceeding the following thresholds based on place of service:
    - One unit equals 15 minutes of additional time:
        - Office or clinic – 2 units
        - Inpatient/outpatient hospital – 4 units
        - Skilled nursing/long term care – 2 units

10. Dental services to be rendered in a hospital or ambulatory surgical center (documentation must include the specific diagnosis and medical conditions that require admission to the hospital or ambulatory surgical center).

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

Family Dental Policy
IND-EHB-FAM-PPO-PD-2019

DELTA DENTAL

Nondiscrimination and Language Assistance Services

Discrimination is Against the Law

Delta Dental complies with applicable Federal civil rights laws. Delta Dental 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:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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
  - Electronic and written translated documents in other languages.

If you need these services, contact our Civil Rights Coordinator.
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:

Compliance Manager
PO Box 103
Stevens Point WI 54481
Phone: 1-715-344-6087, TTY: 711
Fax: 1-715-344-9058
Email: compliance_wi@deltadentalwi.com.

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our 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
1-800-868-1019, 1-800-537-7697 (TDD).

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

SHQIP (Albanian)	VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 1-888-899-3734 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.”
አማርኛ (Amharic)	ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-888-899-3734 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።”
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 الرقم 1-888-899-3734 (711) أو تحدث إلى مقدم الخدمة".
Ikirundi (Bantu – Kirundi)	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-888-899-3734 (TTY: 711).
বাংলা (Bengali)	মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-888-899-3734 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।”
中文 (Chinese)	注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-888-899-3734（文本电话：711）或咨询您的服务提供商。
Cushite (Oromo)	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-899-3734 (TTY: 711).
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 1-888-899-3734 (TTY : 711) ou parlez à votre fournisseur.
Kabuverdianu (French Creole)	ATENÇÃO: Caso fale Kabuverdianu, existem serviços de assistência linguística gratuitos disponíveis. Estão também disponíveis apoios e serviços auxiliares adequados para prestar informações em formatos acessíveis. Ligue 1-888-899-3734 (TTY: 711) ou contacte o seu operador.
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 1-888-899-3734 (TTY: 711) 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 1-888-899-3734 (TTY: 711) 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. 1-888-899-3734 (TTY: 711) 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। 1-888-899-3734 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Lus Hmoob (Hmong)	LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-888-899-3734 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.
Igbo asusu (Ibo)	Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-888-899-3734 (TTY: 711).
Indonesian	PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 1-888-899-3734 (TTY: 711)
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'1-888-899-3734 (tty: 711) o parla con il tuo fornitore.
日本語 (Japanese)	注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-888-899-3734（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。
한국어 (Korean)	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-888-899-3734 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
ɓàsɔ́ɔ̀-wùdù-po-nyɔ̀ (Kru/Bassa)	Dè dɛ nìà kɛ dyédé gbo: Ɔ jǔ ké m̀ [ɓàsɔ́ɔ̀-wùdù-po-nyɔ̀] jǔ ní, nìí, à wudu kà kò dò po-poɔ̀ ɓéìn m̀ gbo kpáa. Đá 1-888-899-3734 (TTY:711)
ລາວ (Laotian)	ຊຶ່ນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-888-899-3734 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.”
Majol (Marshallese)	IKIJEN: Ne kwõj kajin Majol, ewõr jibañ ejellok wonnen ñan kwe ilo kajin eo am. Ebar wõr kein roñjak im jibañ ko rekkar ñan lewaj melele ilo wāween ko kwõmaron loi im ejellok wonnen. Kall ae lok 1-888-899-3734 (TTY: 711) ñe ejab kenono ibben armij ak opij eo ej lewaj jerbal in jjibañ ñan kwe.
ភាសាខ្មែរ (Mon-Khmer, Cambodian)	សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយជ័សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃដងដែរ។ ហៅទូរសព្ទទៅ 1-888-899-3734 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។
नेपाली (Nepali)	सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-888-899-3734 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।
Nilotic	Piŋ apieth: Naa yee jam në Nilotic –Dinka, anɔŋ këde kuɔɔny de thok tɔu tënë yïïn, ke cïn wëu. Yuɔpë 1-888-899-3734 (TTY: 711)
ਪੰਜਾਬੀ (Panjabi)	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-888-899-3734 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।
Pennsylvanian Dutch	Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-888-899-3734 (TTY: 711).

فارسي (Persian)	توجه: اگر [زبان کردن وارد] دسترس در رایگان زبانی پشتیبانی خدمات، کنیدمی صحبت در اطلاعات ارائه برای مناسب پشتیبانی خدمات و هاکمک همچنین دارد قرار شما 1-888-899-3734 شماره با .باشندمی موجود رایگان طوربه دسترس قابل هایقالب (تایپتله: 711) تماس بگیرید یا با کنید صحبت خود دهندهارائه.
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 1-888-899-3734 (TTY: 711) lub porozmawiaj ze swoim dostawcą".
Portuguese	ATENÇÃO: Se você fala [inserir idioma], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-888-899-3734 (TTY: 711) ou fale com seu provedor."
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 1-888-899-3734 (TTY: 711) или обратитесь к своему поставщику услуг.
Srpsko-hrvatski (Serbo-Croatian)	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-899-3734 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).
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 1-888-899-3734 (TTY: 711) o hable con su proveedor.

Tagalog	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 1-888-899-3734 (TTY: 711) o makipag-usap sa iyong provider."
ไทย (Thai)	หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรีนอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-888-899-3734 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ
українська мова (Ukrainian)	УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-888-899-3734 (TTY: 711) або зверніться до свого постачальника».
اردو (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 3734-899-888-1 پر (TTY: 711) (امداد اور خدمات بھی مفت دستیاب ہیں۔ کال کریں یا اپنے فراہم کنندہ سے بات کریں۔"
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 1-888-899-3734 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.
Yoruba	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-888-899-3734 (TTY: 711).