DELTA DENTAL

Your Dental Policy

From Delta Dental of Connecticut, Inc.

Progressive Plan

Delta Dental of Connecticut, Inc.
P.O. Box 16354
Little Rock, AR 72231

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

FORM DDCT-IND-STEP-2019 – PPO SPEC 2021

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WELCOME

Delta Dental of Connecticut, Inc. ("**Delta Dental**") welcomes **You** and the **Dependents You** have signed up for coverage.

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

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

This **Policy** is issued by **Delta Dental of Connecticut, Inc.** and delivered in Connecticut. All terms, conditions, and other rules of this **Policy** are governed by Connecticut 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 terminate by submitting **Your** request in writing to **Delta Dental** at the address shown below or to the insurance broker from whom **You** purchased this **Policy** within 10 days after **You** receive it. Any **Subscription Charges You** paid will be refunded. If **You** received **Benefits** during the 10-day period, **Subscription Charges** paid will be refunded to **You** less the amounts that **We** paid for **Claims**. If **We** do not receive **Your** written request to terminate this **Policy** within the 10-day period, it means **You** accept the terms of this **Policy**.

HOW TO KEEP THIS POLICY IN FORCE

You may keep this **Policy** in force by timely payment of **Subscription Charges**. But, **Delta Dental** may terminate this **Policy** on the following basis:

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

Delta Dental may decide to terminate this **Policy** for the reasons above as of any **Subscription Charges** due date. At least 30-days notice will be given for any termination action under this provision. It will be mailed or e-mailed to **Your** last physical address or e-mail address in **Delta Dental's** records. If **Delta Dental** fails to give 30 -days notice of termination, it will stay in effect until 30 days after notice is given or until the effective date of any replacement coverage, whichever happens first. No **Benefits** will be paid for **Dental Services** incurred during any period for which **Subscription Charges** have not been paid.

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

DELTA DENTAL OF CONNECTICUT, INC.
1639 ROUTE 10
PARSIPPANY, NEW JERSEY 07054

By: /s/Barry Petruzzi
Vice President, Underwriting & Actuarial Services

Table of Contents

Page

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

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

Where a **Dental Service** is a **Covered Service** and **We** pay a **Benefit** for it, **We** base **Our Benefit** on the **Allowed Amount** for the **Service**. That is explained in Section 5.0. The **Allowed Amount** for **Delta Dental Participating Dentists,** that include **Delta Dental PPO℠ Dentists** and **Delta Dental Premier® Dentists** is based on the **PPO Schedule of Fees.** The **Allowed Amount** for **Non-Participating Dentists** is based on the lower of the **PPO Schedule of Fees** or the **Non-Participating Dentist Maximum Allowable Charge.**

The **Delta Dental PPO℠** network includes general **Dentists** and **Dentists** that are specialists (for example, endodontists, oral surgeons, orthodontists, periodontists, prosthodontists). **Dentists** in the **Delta Dental PPO℠** network agree to accept payment based on the applicable **PPO Schedule of Fees**. **Your** financial responsibility to the **Delta Dental PPO℠ Dentist** for **Covered Services** is generally limited to the applicable **Deductible** and **Coinsurance** for the **Dental Service. You** may be able to lower **Your** financial responsibility by choosing to receive **Dental Services** from a **Delta Dental PPO℠ Dentist**. For purposes of this Program, **Dentists** that are specialists in the **Delta Dental Premier®** network are not considered **Delta Dental PPO℠ Dentists**.

You may also choose to receive **Dental Services** from a **Delta Dental Premier® Dentist**. **Delta Dental Premier® Dentists** include general **Dentists** and **Dentists** that are specialists (for example, endodontists, oral surgeons, orthodontists, periodontists, prosthodontists). **Delta Dental Premier® Dentists** agree to accept payment based on the applicable schedule of payments to **Delta Dental Premier® Dentists** referred to as the "**MAC**." **Your** financial responsibility to the **Delta Dental Premier® Dentist** for **Covered Services** will be based on the difference between the **Our** payment, that is based on the **Delta Dental PPO℠ Schedule of Fees** and the **Delta Dental Premier® Dentist's** contracted fee, that is based on the **MAC** schedule**. You** will have a greater financial responsibility when **You** receive **Covered Services** from a **Delta Dental Premier® Dentist** rather than from a **Delta Dental PPO℠ Dentist.**

The **Benefit We** pay the **Delta Dental Participating Dentist** is based on the lowest contracted rate for the plan selected by the **Subscriber.**

If **You** choose to receive **Covered Services** from a **Non-Participating Dentist**, your financial responsibility will be greater than if **You** had received the **Dental Services** from a **Delta Dental**

Participating Dentist. This is because **You** will be responsible for the difference between **Delta Dental's Benefit Amount**, which is based on the lower of the **Delta Dental PPO Schedule of Fees** or the **Non-Participating Dentist Maximum Allowable Charge** and the **Non-Participating Dentist's** full charge for the **Dental Service. Non-Participating Dentists** do not agree to limit **Your** financial responsibility to the applicable schedule of fees.

Remember that **Your** financial responsibility may vary based on the actual fee **Your 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 a filling is 80%, **We** would multiply the **Allowed Amount** by 80%. **We** would pay that amount, subject to the **Benefit Maximum** which is listed in Section 6.2.

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 **Delta Dental Premier® Dentists** and **Delta Dental PPO℠ Dentists** is limited by **Delta Dental** and may be less than the amount 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** 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, **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.

In this Program, **We** will increase both the **Coverage Percent** and the **Benefit Maximum We** pay for certain **Covered Services** upon each of the first two consecutive renewals**.** The **Coverage Percent** paid by **Delta Dental** and the **Benefit Maximum** paid toward most **Covered Services** increases on each of **Your** first two **Policy Anniversary Dates** provided **You** remain consecutively enrolled in this **Policy**. If **You** remain enrolled for more than three **Coverage Periods**, benefits will be covered at the third **Coverage Period** level thereafter. If additional **Covered Persons** are added to the **Policy** after the first **Policy Anniversary Date**, the **Coverage Percent** and the **Benefit Maximum** for these **Covered Persons** will begin at the same level in effect for the **Subscriber** as of the new **Covered Person's** enrollment date.

BENEFIT SUMMARY

Delta Dental Individual-Progressive PPO Plan REFER TO SECTION 7.0 FOR A LIST OF COVERED SERVICES, SPECIFIC LIMITATIONS, ALTERNATE TREATMENT LIMITATIONS AND SPECIFIC EXCLUSIONS THAT APPLY TO EACH COVERED SERVICE. REFER TO SECTION 8 FOR A LIST OF GENERAL EXCLUSIONS THAT APPLY UNDER THIS POLICY					
Procedure Categories	**Does Waiting Period Apply?**	**Does a Deductible Apply?**	**Coverage Percent Paid by Delta Dental (see below for description of the different fee schedules that apply for each category of dentist)**		
			Coverage Period 1	**Coverage Period 2**	**Coverage Period 3**
Diagnostic, Preventive & Emergency Dental Procedures					
Examination or evaluation	No	No	100%	100%	100%
Simple cleanings	No	No	100%	100%	100%
Bitewing X-rays	No	No	100%	100%	100%
Fluoride application	No	No	100%	100%	100%
Full-mouth X-rays (a series of individual X-rays or a panoramic X-ray).	No	No	100%	100%	100%
Sealants on biting surfaces of permanent molars that are unrestored and free of decay.	No	No	100%	100%	100%
Space maintainers when a primary molar tooth is prematurely lost.	No	No	100%	100%	100%
Basic Restorative Services					
Composite filling on anterior (front) teeth and first pre-molars. Amalgam filling on posterior (back) teeth.	No	Yes	40%	60%	80%
Non-surgical extractions	No	Yes	40%	60%	80%
Major Services					
Crowns - Repair of teeth with crowns when they cannot be restored with other filling materials.	No	Yes	30%	40%	50%
Endodontics - The care of teeth with damaged nerves, such as root canal treatment.	No	Yes	30%	40%	50%

Periodontics - The treatment of diseases of the gums and supporting bone, such as scaling and root planing.	No	Yes	30%	40%	50%
Oral Surgery - Tooth extractions and other dental surgery.	No	Yes	30%	40%	50%
Adjunctive General Services - Dental Services include consultations, general anesthesia, and palliative care (temporary treatment of dental pain).	No	Yes	30%	40%	50%
Fixed and Removable Prosthodontics - Dental Services and appliances to replace missing teeth, such as dentures and bridges (excluding implants), including repairs.	No	Yes	30%	40%	50%
Orthodontics			Not Covered	Not Covered	Not Covered
Deductible (per covered person)			$50	$50	$50
Annual Benefit Maximum (per covered person)			$1,500	$1,750	$2,000
Eligibility Age Limits	Qualified Dependents to Age 27				
Network	**Delta Dental PPO℠**				
Dentist Reimbursement	*See Below				

***Dentist Reimbursement**

For **Covered Services** provided by **Delta Dental Participating Dentists** (**Delta Dental PPO℠** and **Delta Dental Premier®**), **Delta Dental's** payment is based on the least of the **Dentists** actual fee, the fee filed by the **Dentist** with **Delta Dental** or the **Delta Dental PPO℠ Schedule of Fees**.

For **Covered Services** provided by **Delta Dental PPO℠ Dentists**, the **Coverage Percentage** is applied to the fee in the **Delta Dental PPO℠ Schedule of Fees**. The **Covered Person's** financial responsibility is limited to the applicable **Deductible** and the **Coinsurance** amount.

For **Covered Services** provided by **Delta Dental Premier® Dentists,** the **Coverage Percentage** is applied to the fee in the **Delta Dental PPO℠ Schedule of Fees**. The **Covered Person's** financial responsibility is based on the **Deductible** and the difference between **Delta Dental's** payment and the applicable **MAC** fee.

For **Covered Services** provided by **Delta Dental Non-Participating Dentists,** the **Coverage Percentage** is applied to the lower of the fee in the **Delta Dental PPO℠ Schedule of Fees or** the **Non-Participating Dentist Maximum Allowable Charge**. The Covered Person's financial responsibility is based on the **Deductible** and the difference between **Delta Dental's** payment and the **Non-Participating Dentist's** full charge.

As noted above, the **Deductible**, **Coinsurance percentage**, **Benefit Maximum**, **Specific Exclusions** and **Specific Limitations and General Exclusions** will also affect the amount **You** owe. See Sections 6.0, 7.0, and 8.0 for details.

Product Descriptions

Note: **Your** benefits do not include coverage of the pediatric dental services that meet the requirements of the federal Patient Protection Affordable Care Act.

Delta Dental PPO℠

Delta Dental PPO℠ Dentists have agreed to accept the least of their actual charge for the service, their filed fee, or the fees in the **Delta Dental PPO℠ Schedule of Fees** applicable to this **Policy** as payment in full for **Covered Services**, offering guaranteed coinsurance payments to covered persons that use a **Dental PPO℠ Dentist**. These fees generally mean lower costs to **You**. **You** may also choose to receive **Covered Services** from a **Delta Dental Premier® Dentist** who is not a **Delta Dental PPO℠ Dentist**. **Delta Dental** will pay the **Delta Dental Premier® Dentist** based on the **Delta Dental PPO℠ Schedule of Fees.** However, Delta **Dental Premier® Dentists** have agreed to accept the least of their actual charge for the service, the filed fee, or the **Maximum Allowable Charge (MAC)** established by **Delta Dental** and agreed to by the **Delta Dental Premier® Dentist**. If **You** select a **Delta Dental Premier® Dentist**, **You** may have to pay the difference between the amount paid by **Delta Dental** based on the **Delta Dental PPO℠ Schedule of Fees** and the **MAC** fee that is the **Approved Amount**. The **MAC** fee may be less than the **Dentist's** actual charge. **Delta Dental's** benefit payment for **Covered Services You** receive from a **Non-Participating Dentist** may be based on the lesser of the dentist's actual charge, the **Delta Dental PPO℠ Schedule of Fees** or the **Non-Participating Dentist Maximum Allowable Charge You** will pay the difference between the amount paid by **Delta Dental** and the full amount charged by the **Non-Participating Dentist**.

Your benefit levels may vary based on the program in which **Your Dentist** participates as indicated in the schedule of benefits which appears in this Policy.

You are responsible for payment of the difference between **Delta Dental's** payment and the fee approved by **Delta Dental**.

1.0 – USING YOUR DENTAL PROGRAM

1.1 About Delta Dental

Delta Dental of Connecticut ("Delta Dental") is a licensed health insurer in Connecticut. **Delta Dental** is a member of the Delta Dental Plans Association. **We** cover people across the country with both individual and employer-sponsored dental programs.

1.2.1 Participating Dentists in Connecticut

Your Policy lets **You** get **Covered Services** from any **Dentist**. But, **Your** out-of-pocket costs may be lower if **You** use a **Delta Dental PPO℠ Dentist. You** may also get **Covered Services** from a **Delta Dental Premier® Dentist,** although **Your** out-of-pocket costs may be higher. However, **Your** cost for **Covered Services You** receive from a **Delta Dental Premier® Dentist,** will be limited to the **MAC,** that may be lower than the **Dentist's** usual fee. The **Policy** covers the same **Dental Services** whether or not **You** use a **Delta Dental PPO℠ Dentist**, a **Delta Dental Premier® Dentist**, or a **Non-Participating Dentist**.

This **Policy** lets **You** select a **Dentist** from two **Delta Dental** networks. They are named **Delta Dental PPO℠** and **Delta Dental Premier®**. **Your** out-of-pocket costs may be lower if **You** use a **Delta Dental PPO℠ Dentist**. Before visiting the **Dentist**, check to see whether **Your Dentist** is a **Delta Dental PPO℠ Dentist** or a **Delta Dental Premier® Dentist**. Remember that if **You** receive **Covered Services** from a **Dentist** who is a specialist, **You** may be able to lower **Your** out-of-pocket costs by going to a specialist who is in the **Delta Dental PPO℠** network.

1.2.2 Delta Dental PPO℠ and Delta Dental Premier® Dentists Outside of Connecticut

You may get **Dental Services** from a **Delta Dental PPO℠ Dentist** or a **Delta Dental Premier® Dentist** outside of Connecticut. To see if **Your** dentist outside of Connecticut is part of the **Delta Dental** network, call Customer Service at 1-888-899-3734 or check **Our** Website at www.deltadentalcoversme.com.

1.2.3 Non-Participating Dentists

You may get **Dental Services** from a **Non-Participating Dentist**. If **You** visit a **Non-Participating Dentist**, **You** will be responsible for making payment to the **Dentist**. **Delta Dental** will pay the **Benefit Amount** to **You**. Because claims must be submitted to **Delta Dental** within twelve (12) 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 (12) months after all **Dental Services** are completed.

1.3 Locating a Participating Dentist

Delta Dental offers two easy ways to find a **Delta Dental Participating 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 **Delta Dental Participating Dentists** to allow **You** to select either a **Delta Dental PPO℠ Dentist** or a **Delta Dental Premier® Dentist** within the area of **Your** request. **Delta Dental** mails the list to **Your** home. By searching on **Our** Website, **You** can get a customized list of **Delta Dental Participating Dentists** in a specific area. The list can be downloaded right away. **You** can search any area as needed. Using either method, **You** can get listings of general **Dentists** only or specialists only. **You** can get **Delta Dental Participating Dentist** information for the whole country when **You** travel outside of Connecticut.

1.4 Selecting a Delta Dental Participating Dentist

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

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

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

- **Delta Dental Premier® Dentists** 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.

- If **You** visit a **Non-Participating Dentist**, **You** will be responsible for making payment to the **Dentist** for any amount not paid to them by us. **Delta Dental** will pay the **Benefit Amount** to **You** or as required by law. **You** will also get an **Explanation of Benefits**.

In the event a **Delta Dental Premier® Dentist** or a **Delta Dental PPO℠ Dentist,** is not accessible for one of the following reasons below, **You** may receive a benefit for a **Covered Service** performed by a **Non-Participating Dentist** at the same coverage and benefit level that applies to a **Delta Dental Premier® Dentist** or a **Delta Dental PPO℠ Dentist**:

- **You** cannot access a **Delta Dental Premier® Dentist** or a **Delta Dental PPO℠ Dentist** within a reasonable driving distance of **Your** residence; or
- **You** cannot schedule an appointment with a **Delta Dental Premier® Dentist** or a **Delta Dental PPO℠ Dentist** within a reasonable timeframe; or
- There is no **Delta Dental Premier® Dentist** or **Delta Dental PPO℠ Dentist** that can provide the type of **Covered Service** needed by **You**; or

- There are no **Delta Dental Premier® Dentists** or a **Delta Dental PPO℠ Dentists** accepting new patients.

If a **Delta Dental Premier® Dentist** or a **Delta Dental PPO℠ Dentist**, is not accessible for one of these reasons, call **Our** Customer Service Department to assist in finding a **Dentist** or scheduling an appointment for **You** either with a **Delta Dental Premier® Dentist** or a **Delta Dental PPO℠ Dentist** or with a **Non-Participating Dentist.**

If we cannot find a **Delta Dental Participating Dentist** for **You** and approve **Your** visit with a **Non-Participating Dentist, You** will be entitled to receive the same benefit that would be available if the **Covered Services** had been received from **Delta Dental Premier® Dentist** or a **Delta Dental PPO℠ Dentist** in the same geographic area. **You** will pay the same amount that **You** would have paid if **You** received the **Covered Service** from **Delta Dental Premier® Dentist** or a **Delta Dental PPO℠ Dentist** in the same geographic area and **We** will either pay the **Non-Participating Dentist's** fee or negotiate a payment with the **Non-Participating Dentist.** The amount **We** pay that is more than what **We** would have paid for the **Covered Service** had **You** received it from **Delta Dental Premier® Dentist** or a **Delta Dental PPO℠ Dentist** will not apply to the annual **Benefit Maximum** or the **Benefit Maximum** for the **Covered Service** as provided under the terms of the **Policy.**

1.5 Your First Dental Visit

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

If **Your Dentist** submits a proposed treatment plan to **Delta Dental**, **Delta Dental** will supply a **Pre-Treatment Estimate**. This will let **You** and **Your Dentist** find out how much of the charge **You** owe. Before treatment is started, be sure **You** talk with **Your Dentist** about the total amount of his or her fee. **Pre-Treatment Estimates** are not required. But, **Delta Dental** suggests **You** ask **Your Dentist** to send a request for **Pre-Treatment Estimate** for treatment costing $300 or more. This is very important when using a **Non-Participating Dentist**. Keep in mind that **Pre-Treatment Estimates** are only estimates and not promises or guarantees of payment.

1.6 Contacting Delta Dental

<u>On the Web</u>

Visit us at www.deltadentalcoversme.com to create an account for our secure Web site. Once signed up, **You** can check **Your Covered Services** and eligibility. **You** can check claim payments and view the **Benefit Maximum** and **Deductible** balances for all of the people covered under **Your Policy**. **You** can also print more copies of **Your** ID Card for **You** and/or **Your Covered Dependents**.

By Phone

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

- Confirming eligibility for **Benefits**
- Helping **You** understand **Your Policy**
- Checking the status of a **Claim**
- Determining how much of **Your Deductible** or **Benefit Maximum** is left
- Locating a **Delta Dental PPO℠ Dentist** or a **Delta Dental Premier® Dentist**

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

By Mail
Delta Dental of Connecticut, Inc.
c/o 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. **"Adverse Benefit Determination"** means a decision **Delta Dental** makes resulting in a **Benefit Amount** which is less than the amount submitted on the **Claim**. This includes **Delta Dental** not paying any **Benefit Amount** for the **Dental Service**.

2. **"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**.

3. **"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.

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

5. **"Approved Amount"** means the total fee which the **Delta Dental Premier® Dentist** or **Delta Dental PPO℠ Dentist** has agreed to accept as payment in full for the **Dental Service** provided. It includes both **Delta Dental's Benefit Amount** and the **Covered Person's** payment obligation. For **Dental Services** performed by a **Non-Participating Dentist**, it is the amount actually charged.

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

7. "**Benefit Limitations**" are restrictions on the **Benefit Amounts** payable under this **Policy**. **Benefit Limitations** include the following: (a) the **Coverage Percent** specified in Section 7.0; (b) the **Deductible** amount and the **Benefit Maximum** specified in Section 6.0; (c) the limit on the **Approved Amount** for the **Dental Service** specified in Section 5.0; (d) the **Alternate Treatment Limitation** described in Section 6.6, and (e) the **Specific Limitations** contained in 7.0.

8. "**Benefit Maximum"** means the total dollar limit that **Delta Dental** will pay toward **Covered Services** for each **Covered Person** during a **Coverage Period**. See Section 6.2. For purposes of this **Policy,** the **Benefit Maximum** will increase upon renewal on each of **Your** first two **Policy Anniversary Dates** provided that **You** remain consecutively enrolled in this **Policy**. After the third consecutive **Coverage Period** that this **Policy** remains in effect, the **Benefit Maximum** will remain the same as it was in the third **Coverage Period.**

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

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

11. **"Coinsurance Percent"** means the percentage of the **Allowed Amount** for a **Covered Service** paid by the **Subscriber** or **Covered Dependent** after any applicable **Benefit Limitations**.

12. **"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**.

13. **"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.

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

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

16. **"Coverage Percent"** means the percentage of the **Allowed Amount** to be paid by **Delta Dental** for a **Covered Service**. For purposes of this **Policy,** the **Coverage Percent** will increase upon renewal on each of **Your** first two **Policy Anniversary Dates** provided that **You** remain consecutively enrolled in this **Policy**. After the third consecutive **Coverage Period** that this **Policy** remains in effect, the **Coverage Percent** will remain the same as it was in the third **Coverage Period.**

17. **"Coverage Period**" means the term of this **Policy**, in months, beginning on the **Coverage Effective Date** and ending on the **Coverage Expiration Date**, during which covered **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**.

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

19. **"Covered Person"** means the **Subscriber** and each of his or her **Covered Dependents**. A person shall no longer be a **Covered Person** under this **Policy** at the point when such person stops meeting the definition of **Subscriber** and/or **Covered Dependent** or as of the **Coverage Expiration Date**.

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

21. **"Deductible"** means the specified dollar amount that **You**, or a **Covered Dependent**, are required to pay toward a **Covered Service** each **Coverage Period** before **Delta Dental** will pay any **Benefit** toward the **Covered Service**. That dollar amount is specified in Section 7.0 of this **Policy**.

22. **"Definitive Procedure"** means any **Dental Service** which has been given a Current Dental Terminology (CDT) procedure code. **Definitive Procedures** may be combined for payment purposes. That a **Dental Service** that has been assigned a CDT procedure code does not mean it is a **Covered Service**.

23. **"Delta Dental"** means Delta Dental of Connecticut, Inc.

24. **"Delta Dental Participating Dentist"** means a **Dentist** who is a **Delta Dental PPO℠ Dentist** or a **Delta Dental Premier® Dentist** as defined in this **Policy.**

25. "**Delta Dental Premier® Dentist"** means a **Dentist** who has a **Delta Dental Premier® Dentist** participation agreement in force with **Delta Dental,** or a similar contract with **Another Delta Dental Plan** and has agreed to accept payments from **Delta Dental** on the basis provided in this **Policy**. For purposes of this **Policy,** a **Delta Dental Premier® Dentist** includes general **Dentists** and **Dentists** who are specialists. A **Delta Dental Premier® Dentist** who is a specialist is (a) a **Dentist** who has a participation agreement in force with **Delta Dental** or **Another Delta Dental Plan**; (b) holds a current specialty permit in the state where the **Dentist** performs **Dentistry** in periodontics, prosthodontics, endodontics, or oral surgery and limits his or her practice to the respective specialty; and (c) has registered with **Delta Dental** or **Another Delta Dental Plan** as a specialist.

26. **"Delta Dental PPO℠ Dentist"** means a **Dentist** who has a **Delta Dental PPO℠ Dentist** agreement in force with **Delta Dental** or a similar contract with **Another Delta Dental Plan** for **Dentists** in that respective state. **Delta Dental PPO℠ Dentist** includes a **Dentist** who is a general **Dentist** or a **Dentist** who is a specialist.

27. **"Delta Dental Premier® Dentist Maximum Approved Charge"** or **"MAC"** is defined as the highest applicable amount which **Delta Dental** approves for purposes of compensating the **Delta Dental Premier® Dentist** for a **Dental Service.** This includes the amount payable by both **Delta Dental** and the **Covered Person.** There may be a **MAC** for **Delta Dental Premier® Dentists** that are general **Dentists** and a **MAC** for **Delta Dental Premier® Dentists** that are specialists. The applicable **MAC** amount may vary by state or by region within a state.

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

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

30. "**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 in which they were rendered within the scope of his/her education, training and experience.

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

32. "**Dependent Child**" means children of the **Subscriber** less than 27 years of age. They include stepchildren, foster children, and legally adopted children.

33. **"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).

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

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

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

37. "**Non-Participating Dentist**" means any **Dentist** other than a "**Delta Dental Participating Dentist**" such as a "**Delta Dental PPO℠ Dentist**" or a **Delta Dental Premier® Dentist** as defined in this **Policy**.

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

39. **"Policy"** means this document.

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

41. **"PPO Schedule of Fees"** means the highest applicable amount which Delta Dental approves for purposes of compensating **Delta Dental PPO℠ Dentists** that are general **Dentists** or specialists.

The **PPO Schedule of Fees** is approved by **Delta Dental** or **Another Delta Dental Plan** for **Dental Services** that are **Covered Services**. It is changed from time to time by **Delta Dental** or by **Another Delta Dental Plan**. The amount may vary by state or by region within a state. For purposes of this **Policy, Delta Dental** makes payments to **Delta Dental PPO℠ Dentists**, **Delta Dental Premier® Dentists,** and to **Non-Participating Dentists**, based on the applicable **PPO Schedule of Fees**.

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

43. **"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).

44. **"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.

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

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

47. "**Spouse**" means the **Subscriber's** lawful **Spouse**.

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

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

50. **"Subscription Rate Type"** 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. "Individual and **Spouse**" means coverage is provided for the **Subscriber** plus the **Subscriber's Spouse**.
    c. "Individual and **Dependent Child**" means coverage is provided for the **Subscriber** plus the one **Covered Dependent Child** named in this **Policy**;
    d. "Family" means coverage is provided for the **Subscriber**, the **Subscriber's Spouse**, and one or more **Dependent Children** that are named in this **Policy**.

e. "Individual and **Dependent Children**" means coverage is provided for the **Subscriber** and one or more **Dependent Children** that are named in this **Policy**.

51. **"We," "Us,"** and **"Our"** means Delta Dental of Connecticut.

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

3.0 – ELIGIBILITY AND ENROLLMENT

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

1. have filled in and signed the proper application;
2. have been accepted by **Delta Dental** for coverage;
3. have paid **Your Subscription Charges**;
4. are not eligible for company-sponsored or any other group dental coverage;
5. are not actively covered under any type of group or individual dental coverage;
6. are 18 years of age or an emancipated minor; and
7. are a permanent, legal resident of Connecticut.

A permanent, legal resident is a person who lives in Connecticut 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 Connecticut state driver's license or voter's registration card. **You** can also provide a current month's utility bill with **Your** home street address or other similar proof. Tell **Delta Dental** if **You** move outside of Connecticut within thirty (30) days. **We** will end coverage effective as of the last day of the **Coverage Period**.

If **You** choose to cover **Your Dependents**, eligibility begins on the first day **You** become covered under **Your Policy**. New **Dependents** can be added under the Changing Coverage section below. Please refer to the **Schedule of Covered Services** for more information.

3.1 - Covered Dependents

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

1. **Your Spouse**;

2. A **Dependent Child**, or;

3. A disabled child of the **Subscriber** or **Spouse** over the age of 27 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.

3.2 – Continued Dependent Coverage
A **Covered Dependent** (**Spouse** and/or **Child**) may choose to keep his or her coverage under this **Policy** as a **Subscriber** with his or her own **Policy** if:

1. The **Subscriber** dies;
2. The **Subscriber** and **Spouse** divorce.

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

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

1. marriage;
2. divorce or legal separation;
3. birth or adoption of a child;
4. hospice care of a **Covered Person**;
5. death of a **Covered Person**;
6. a **Covered Dependent's** loss of other dental coverage; or,
7. a court orders **You** to give dental coverage to a **Dependent**, even if **You** are not the custodial parent.

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

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

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

3.4 - Your Coverage Period

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

Eligibility for **Covered Dependents** ends:

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

2. when a **Covered Dependent** Child reaches his or her 27th birthday;

3. for a disabled child, the last day of the year when the disabled **Dependent** is no longer physically or mentally incapacitated as described in Section 3.1; or

4. for all **Covered Dependents**, the last day of the month when the **Subscriber** becomes deceased;

5. Upon termination of **Subscriber's** coverage.

If Your coverage under this Policy is terminated or cancelled for any reason, and not reinstated by Us prior to the Coverage Expiration Date, You cannot sign up for a Delta Dental Individual Policy for 24 months from the date of termination or cancellation. You will also not be eligible for the benefits of continuous coverage for purposes of increased **Benefit Maximums** and **Coverage Percentages** available under this **Policy.**

Fraudulent Information
If **You** gave false or misleading information to defraud **Delta Dental**, this **Policy** can be terminated. **We** shall tell the proper state and regulatory authorities. It is a crime to give false, incomplete, or misleading information on purpose to defraud **Delta Dental** or receive or attempt to receive payments or **Benefits You** are not entitled to. Penalties include imprisonment, fine, and denial of **Benefits**.

4.0 – SUBSCRIPTION CHARGES, POLICY RENEWAL, AND TERMINATION

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

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

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

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

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

1. The number of **Your Covered Dependents** changes;
2. There is a change in law or rule that affects this **Policy's Benefits**.

If **You** have pre-paid the **Subscription Charges** for a month in which a change in the **Subscription Charges** due to items 1, 2 or 3 listed above 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 or Electronic Funds Transfer (EFT) through a checking or savings account.

4.6 - Renewal, Amendment or Modification
Delta Dental reserves the right to change the terms of this **Policy** at the **Policy Anniversary Date**. This includes the **Covered Services, Benefit Limitations** and **Exclusions,** and the applicable **Subscription Charges**. **We** will give at least ninety (90) days written notice of such changes prior to the **Anniversary Date**. Such changes shall be in effect for all **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** for **You** or for **Your Covered Dependents** during the **Coverage Period**. **You** must tell **Us** in writing 30 days before the date **You** want coverage to end. Coverage will end for **You** and any of **Your Covered Dependents** on the next scheduled **Subscription Charge** due date.

If You terminate coverage, You may not be able to sign up for a Delta Dental Individual Policy for 24 months from the date of termination.

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

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

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

4.9 - Payment of Benefits After Termination
A **Claim** for a **Dental Service** must be filed within twelve (12) months after the date the **Dental Service** was finished. **You** or **Your Covered Dependents** will be responsible for payment of any **Dental Services** finished after termination of **You** or **Your Covered Dependent's** coverage because they are **Excluded** (see Section 8.0(2)(kk)).

5.0 – CHOOSING A DENTIST
With this **Policy**, **You** may select any **Dentist**. **Your** out-of-pocket costs *may* be lower if **You** choose a **Delta Dental PPO℠ Dentist**. **Delta Dental** offers two easy ways to find these **Dentists** 24 hours a day, 7 days a week. **You** can either:

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

Delta Dental Customer Service can also help **You** locate these **Dentists**.

5.1 - Delta Dental PPO℠ Dentists
You may receive services from **Dentists** that are in the **Delta Dental PPO℠** network. **Delta Dental PPO℠ Dentists** send **Claims** and get payment straight from **Delta Dental**. For **Covered Services, You** will generally be responsible for paying the **Deductible** and the applicable **Coinsurance** that is based on the **Coverage Percentage. You** will be responsible for the difference between the amount paid by **Delta Dental** based on the **PPO Schedule of Fees** and the least of the **Dentist's** actual fee, the fee the **Dentist** has filed with **Delta Dental,** or the **PPO℠ Schedule of Fees**. **You** will be responsible for the amount not paid by **Delta Dental** under this **Policy**. This includes amounts **Delta Dental** did not pay because the **Dental Services** were not **Covered Services** or due to **Benefit Limitations** or **Exclusions**. Selecting a **Delta Dental PPO℠ Dentist** *may* lower **Your** out-of-pocket costs. Please remember that **Delta Dental Premier® Dentists** that are specialists are not **Delta Dental PPO℠ Dentists** for purposes of this **Policy**. To lower **Your** financial responsibility, if **You** require services from **Dentist** who is a specialist, please select a **Dentist** who is in the **Delta Dental PPO℠** network.

5.2 - Delta Dental Premier® Dentists

You may also receive services from **Dentists** that are in **Delta Dental's Premier®** network. **You** may select a **Delta Dental Premier® Dentist** who is a general dentist or is a specialist**.** These **Dentists** agree to provide treatment for **Covered Persons** based on the terms of the agreement with **Delta Dental** or **Another Delta Dental Plan**. **Delta Dental Premier® Dentists** will fill out and send the **Claim** to **Delta Dental**. They also get payment straight from **Delta Dental**. For **Covered Services, You** will be responsible for paying the **Deductible** and the applicable **Coinsurance** that is based on the **Coverage Percentage** and pay the difference between the amount paid by **Delta Dental** based on the **PPO Schedule of Fees** and the least of the **Dentist's** actual fee, the fee the **Dentist** has filed with **Delta Dental;** or the applicable **Delta Dental Premier® Dentist Maximum Approved Charge** (**MAC**). **You** will be responsible for the amount not paid by **Delta Dental** under this **Policy**. This includes amounts **Delta Dental** did not pay because the **Dental Services** were not **Covered Services** or due to **Benefit Limitations** or **Exclusions**. **Your** financial responsibility may be less if **You** elect to receive **Covered Services** from a **Delta Dental PPO℠ Dentist.** However, **You** may still experience some financial savings from going to a **Delta Dental Premier® Dentist**, since **Delta Dental Premier® Dentists** agree to limit the fee for **Covered Services** to the applicable **MAC.**

5.3 - Nonparticipating Dentists

If **You** receive services from a **Non-Participating Dentist, Your** financial responsibility may be greater than if **You** received services from a **Delta Dental PPO℠ Dentist** or a **Delta Dental Premier® Dentist. Delta Dental** will base its payment for **Covered Services** based on the lower of the actual charge, the **PPO Schedule of Fees**, or the **Non-Participating Dentist Maximum Allowable Charge. You** will be responsible for paying the **Deductible** and the applicable **Coinsurance** that is based on the **Coverage Percentage** and pay the difference between the amount paid by **Delta Dental** based on the lower of the **PPO Schedule of Fees** or the **Non-Participating Dentist Maximum Allowable Charge** and the **Non-Participating Dentist's** actual charge. **You** or **Your Non-Participating Dentist** must send **Claims** to **Delta Dental**. 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 You** receive from **Non-Participating Dentists** within twelve months after all **Dental Services** are completed. **You** will be responsible for the amount not paid by **Delta Dental** under this **Policy.** This includes amounts **Delta Dental** did not pay because the **Dental Services** were not **Covered Services** or due to **Benefit Limitations** or **Exclusions.**

Be sure to talk to Your Dentist about any charges You may owe before treatment begins.

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

These examples are for illustration purposes. The first example assumes no **Benefit Maximums** or **Deductibles** apply. The second example shows how **Deductibles, Benefit Maximums** or **Alternate Benefits** can affect the **Benefit Amount**. To verify how **Delta Dental PPO℠ Dentists** and **Delta**

Dental Premier® Dentists who are specialists are paid outside of Connecticut, **You** must get in touch with the local **Delta Dental** plan operating in that state. **You** can find this information at www.deltadental.com under "**Subscribers**" and "Member Company Locator."

Dentist Type & Network	**Delta Dental PPO℠ Dentist (Delta Dental PPO SM network)**	**Delta Dental Premier® Dentist (Delta Dental Premier® network)**	**Non-Participating Dentist**
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 the **Delta Dental PPO℠ Schedule of Fees**.	**You** will be responsible for the difference between **Delta Dental's Benefit Amount** and the least of the **Delta Dental Premier® Dentist's** actual fee, the fee the **Dentist** has filed with **Us,** or the applicable **Delta Dental Premier® Dentist Maximum Approved Charge**. **Delta Dental's Benefit Amount** is based on the least of the **Dentist's** actual fee, the fee the **Dentist** has filed with **Us**, or the **Delta Dental PPO℠ Schedule of Fees**.	**You** will be responsible for the difference between **Delta Dental's Benefit Amount** and the **Dentist's** actual fee. **Delta Dental's Benefit Amount** is based on the least of the **Dentist's** actual fee , the fee in the **Delta Dental PPO Schedule of Fees**, or the fee in the **Non-Participating Dentist Maximum Allowable Charge**
Example*	**Delta Dental PPO SM Dentist**	**Delta Dental Premier® Dentist**	**Non-Participating Dentist**
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	$640	$640
Coverage Percent	50%	50%	50%
Delta Dental Payment	$320	$320	$320
Patient Payment	$640 - $320 = **$320**	$800 - $320 = **$480**	$1,000 - $320 = **$680**

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

	Delta Dental PPO [SM] **Dentist**	**Delta Dental Premier® Dentist**	**Non-Participating Dentist**
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 $1,000 $ 800
Allowed Amount less **Deductible** for **Dental Service** No. 1	1. $1,000 - $50 = 950	$1,000 - $50 = $950	$1,000 - $50 = $950
Allowed Amount for **Dental Service** No. 2	2. $640	$640	$640
Alternate Treatment - **Allowed Amount** for **Dental Service** No. 3	3. $350	$350	$350
Total **Allowed Amount**	$1,940	$1,940	$1,940
Coverage Percent	1. 50% 2. 50% 3. 50%	50% 50% 50%	50% 50% 50%
Delta Dental Benefit Amount Before **Benefit Maximum** (Assumes $1,000 **Benefit Maximum**)	$970	$970	$970
Total **Delta Dental Benefit Amount**	$970	$970	$970
Patient's Payment (Approved Total Amount Less **Delta Dental Benefit** Payment Amount)	$2,120 - $970 = **$1,150**	$2,500 - $970 = **$1,530**	$3,000 - $970 = **$2,030**

6.0 – POLICY COVERAGE TERMS

The following sections outline the **Policy** Terms and the **Schedule of Benefits**. These sections will give **You** information about **Your Deductibles**, **Benefit Maximums**, **Coverage Percentage**, and the **Benefit Limitations** and **Exclusions**.

6.1 – Deductibles

The **Deductible** for **Covered Services** for each **Coverage Period** for as long as this Policy is in force is $50 for **You** and for each **Covered Dependent**. Once a **Covered Person** has paid his **Deductible** for the **Coverage Period**, no additional **Deductible** is required to be paid for **Covered Services** during that **Coverage Period**. Preventive and diagnostic services are not subject to a **Deductible** under this **Policy**. There are no **Deductibles** that apply to this **Policy**.

6.2 – Benefit Maximum

The **Benefit Maximum** paid toward **Covered Services** increases upon renewal on each of **Your** first two **Policy Anniversary Dates** provided **You** remain consecutively enrolled in this **Policy**. If **You** remain enrolled for more than three **Coverage Periods**, the **Benefit Maximum** will continue to be at the same as it was during the third **Coverage Period**. This applies separately for each **Covered Person**. Once the **Benefit Maximum** is reached, **You** pay 100% of the **Approved Amount** of any **Dental Service** received. If **You** do not use any or all the **Benefit Maximum** during the **Coverage Period**, **You** cannot carry any leftover balances to a future **Coverage Period**. The **Benefit Maximum** under this **Policy** is $1,500 for the first **Coverage Period**, $1,750 for the second **Coverage Period**, and $2,000 for the third and all subsequent **Coverage Periods** as long as **You** continue **Your** enrollment in this **Policy**. If **You** add additional **Covered Persons** to **Your Policy** after **Your** first **Policy Anniversary Date**, the **Benefit Maximum** for each additional **Covered Person** will be at the same as **Your Benefit Maximum** at the time the additional **Covered Person** is added.

6.3 - Coverage Percent

The **Coverage Percent** that applies to each category of **Covered Services** increases upon renewal on each of **Your** first two **Policy Anniversary Dates** provided **You** remain consecutively enrolled in this **Policy.** If **You** remain enrolled for more than three **Coverage Periods**, the Coverage Percent will continue to be the same as it was during the third **Coverage Period**. The **Coverage Percent** for each category of **Covered Services** is listed in Section 7.0 of this **Policy**. **Delta Dental** will pay the **Coverage Percent** that applies to the **Covered Service** based on the applicable **PPO Schedule of Fees.**

If **You** add additional **Covered Persons** to **Your Policy** after **Your** first **Policy Anniversary Date**, the **Coverage Percent** for each additional **Covered Person** will be at the same level as **Your Coverage Percent** at the time the additional **Covered Person** is added. 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 "50%," **Delta Dental** will pay 50% of the **Allowed Amount** for the **Covered Service**, after any applicable **Deductible**. The amount that **You** must pay is the difference between the **Benefit** paid for the **Dental Service** and the **Approved Amount** for the **Dental**

Service.

6.4 - Benefit Waiting Period
This **Policy** has no Benefit Waiting Period.

6.5 – Benefit Limitations and Exclusions
This **Policy** does not cover every aspect of dental care and every **Dental Service** recommended or performed by a **Dentist**. This **Policy** provides payment only toward **Covered Services**. **Covered Services** are subject to **Benefit Limitations** and **Exclusions** listed in Schedule 7.0 and 8.0.

When Schedule 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**.

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

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

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.

IMPORTANT: If **You** opt to receive **Dental Services** or procedures that are not **Covered Services** under this **Policy,** a **Delta Dental Participating Dentist** may charge **You** his or her usual and customary rate for such services or procedures. Prior to providing **You** with dental services or procedures that are not **Covered Services**, the **Delta Dental Participating Dentist** should provide **You** with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure.

Please refer to Section 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**.

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 (per Coverage Period)**			**Covered Services**
No	**1st**	**2nd**	**3rd or more**	Dental evaluations, including comprehensive, routine and emergency evaluations, as well as consultations
	100%	100%	100%	

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, including an oral evaluation for a **Patient** less than three years of age, performed by the **Same Dentist** within 3 years. Evaluations within 3 years after a **Comprehensive** evaluation by the **Same Dentist** will be **Benefited As** periodic evaluations.

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

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

Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
No	**1st**	**2nd**	**3rd or more**	Intraoral complete mouth series (CMX) (series of individual x-rays and panoramic x-rays)
	100%	100%	100%	

Diagnostic and Preventive Services

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 3 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 (per Coverage Period)			Covered Services
No	**1st**	**2nd**	**3rd or more**	Intraoral radiographs
	100%	100%	100%	

Specific Limitations

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

Deductible	Coverage Percent Paid By Delta Dental (per Coverage Period)			Covered Services
No	**1st**	**2nd**	**3rd or more**	Bitewing x-rays (one set equals one or more bitewing films taken on the same day)
	100%	100%	100%	

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 (per Coverage Period)			Covered Services
No	**1st**	**2nd**	**3rd or more**	Pulp vitality test
	100%	100%	100%	

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.

Deductible	Coverage Percent Paid By Delta Dental (per Coverage Period)			Covered Services
No	**1st**	**2nd**	**3rd or more**	Prophylaxis (teeth cleaning)
	100%	100%	100%	

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				
Prophylaxes for persons age 14 and older are **Benefited As** adult prophylaxes. Prophylaxes for persons under age 14 are **Benefited As** child prophylaxes.				
Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
No	**1st**	**2nd**	**3rd or more**	Office applied topical fluoride applications including fluoride varnish (per visit)
	100%	100%	100%	
Specific Limitations No **Benefit** will be paid for topical fluoride treatment (a) more than twice (2) per 12-month period, or (b) for **Covered Persons** age 19 and older.				
Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
No	**1st**	**2nd**	**3rd or more**	Space maintainers (includes teeth, clasps, rests and other components) for retaining space when a primary posterior tooth is prematurely lost
	100%	100%	100%	
Specific Limitations No **Benefit** will be paid for space maintainers: (a) more than once (1) per-arch in a lifetime, (b) for missing permanent teeth, (c) for missing primary anterior teeth, or (d) for persons age 14 and older.				
Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
No	**1st**	**2nd**	**3rd or more**	Recementation of space maintainer
	100%	100%	100%	
Specific Limitations No **Benefit** will be paid for recementation of space maintainers more than once (1) per **Patient** in a lifetime.				
Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
Yes	**1st**	**2nd**	**3rd or more**	Application of sealants Preventive resin restorations
	100%	100%	100%	
Specific Limitations No **Benefit** will be paid for sealants and preventive resin restorations: (a) for persons age 16 and older, (b) when applied to any tooth surface other than the occlusal surface of permanent molars which are free of restorations and decay (including , sealants, preventive resin restorations placed on the occlusal surface of the same tooth on the same day). No **Benefit** will be paid for more than one (1) of either procedure (sealant or preventive resin restoration) per tooth in a lifetime.				
Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
Yes	**1st**	**2nd**	**3rd or more**	Emergency Treatment to relieve pain
	30%	40%	50%	

Diagnostic and Preventive Services
Specific Exclusions & Alternate Treatment Limitations

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

Specific Exclusions

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

- Images such as cephalometric films, oral facial photographs, lateral skull and facial survey, cone beam capture and imaging.
- Tests such as bacteriologic tests, collection of microorganisms for culture and sensitivity, saliva tests, viral cultures, genetic tests, tests for susceptibility to caries (decay) and other oral diseases, pre-diagnostic cancer screening tests, medical tests and screenings.
- Oral pathology laboratory procedures.
- Diagnostic casts.
- Procedures such as nutritional and tobacco counseling, oral hygiene instructions, risk assessment, and counseling.
- Fluoride gels, rinses, tablets, or other preparations meant for home application.
- A prophylaxis paste containing fluoride or a fluoride rinse or swish.
- Repair and removal of space maintainers.
- Procedures mainly for plaque control.

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

Alternate Treatment Limitations

The **Benefit Amount** for full mouth debridement will be determined based on the **Benefit Amount** for prophylaxis subject to the above **Specific Limitations** and **Specific Exclusions** applicable to prophylaxis. The **Covered Person** 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.

Basic Restorative Services

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

Deductible	Coverage Percent Paid By Delta Dental (per Coverage Period)			Covered Services
Yes	**1st**	**2nd**	**3rd or more**	Amalgam (silver) fillings Composite (tooth colored) fillings - anterior teeth only
	40%	60%	80%	

Specific Limitations

No **Benefit** will be paid for amalgam (silver) fillings or composite (tooth colored fillings: (a) more than once (1) per surface of the same tooth per 24-month period, or (b) when performed on the same day or within 12 months

Basic Restorative Services				
following a post and core on the same tooth unless necessary due to caries, as a crown repair for a fracture, or access opening for root canal treatment.				
Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
Yes	**1st**	**2nd**	**3rd or more**	Non-surgical Extractions
	40%	60%	80%	

Specific Limitations

No **Benefit** will be paid for local anesthesia and suturing (if needed) when performed by the **Same Dentist** on the same day as oral and maxillofacial surgery.
No **Benefit** will be paid for routine postoperative care and treatment of dry socket: (a) when performed by the **Same Dentist** who performed the surgery, or (b) more than once (1) per visit.

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

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

Basic Restorative Services
Specific Exclusions & Alternate Treatment Limitations

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

Specific Exclusions
Any restorative procedure not specifically listed as a **Covered Service**. The following are also specifically **Excluded**:

- Multiple pins in the same tooth
- Any procedures, restorations, or appliances associated with periodontal splinting
- Any restorative procedure not due to decay or fracture
- Protective restorations

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

Alternate Treatment Limitations
Benefits will be paid for composite restorations only when placed in front teeth and first premolars. **Benefits** for posterior teeth other than first premolars will be based on amalgam restorations. The **Benefit** for composite restorations will be determined based on the **Benefit Amount** for amalgam restorations subject to the above **Specific Limitations** and **Specific Exclusions** applicable to amalgam restorations. The **Covered Person** is responsible for the difference between the **Benefit Amount** for the amalgam restorations and the **Approved Amount** for the **Dental Service** actually rendered.

Restorative – Crowns and Onlays				
Dental Services involving restoration covering or replacing the major part or the whole of the clinical crown of a tooth and must overlay or hood one or more cusp tips.				
Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
Yes	**1st**	**2nd**	**3rd or more**	Indirectly fabricated single crowns, onlays, post & cores, and core build-ups
	30%	40%	50%	
Specific Limitations No **Benefits** will be paid for indirectly fabricated single crowns, onlays, post & cores, and core build-ups: (a) for primary ("baby") teeth, or (b) when replaced on the same day or within 7 years from the date of the prior major restorative **Dental Services**, even if **Delta Dental** did not cover the **Patient** and/or pay a **Benefit** toward the prior **Dental Service**. For purposes of applying this Frequency Limit, implant supported or natural teeth onlays, indirectly fabricated crowns, fixed partial dentures, removable partial dentures, immediate and complete dentures are counted against themselves and each other. No **Benefit** will be paid for a core buildup when performed with or in addition to an amalgam restoration, resin-based composite restoration, inlays, onlays, or any other type of post and core.				
Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
Yes	**1st**	**2nd**	**3rd or more**	Prefabricated stainless steel and resin crowns
	30%	40%	50%	
Specific Limitations No **Benefit** will be paid for prefabricated stainless steel or resin crowns when replaced within a 24-month period of time.				
Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
Yes	**1st**	**2nd**	**3rd or more**	Crown repairs and recementation of crowns, onlays, post and cores
	30%	40%	50%	
Specific Limitations No **Benefit** will be paid for recementation of crowns, onlays, post and cores: (a) on the same day or within 6 months after the first insertion by the **Same Dentist**, (b) more than once (1) in a 12-month period. No **Benefit** will be paid for recementation of a post when performed on the same day as a single crown or fixed partial denture recementation.				

Restorative – Crowns and Onlays
Specific Exclusions & Alternate Treatment Limitations

The following **Specific Exclusions** and **Alternate Treatment Limitations** apply to restorative – crowns and onlays:

Specific Exclusions

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

- Inlays and recementation of inlays
- Gold foil restorations
- Copings (considered a specialized technique)
- Provisional or temporary or interim crowns
- Any procedures, restorations, or appliances associated with periodontal splinting
- Any restorative procedure not due to decay or fracture
- Removal of posts
- Veneers

No **Benefit** will be paid for indirectly fabricated crowns and onlays unless the teeth cannot be restored with silver amalgam or composite resins (or other material approved by **Delta Dental** at its sole discretion). No **Benefit** will be paid for this **Dental Service** unless the tooth cannot be restored by any other means.

Alternate Treatment Limitations

The **Benefit** for onlays, indirectly fabricated crowns, and posts and cores for children under 12 years of age will be determined based on the **Benefit Amount** for prefabricated resin crowns for front teeth or prefabricated stainless steel crowns for back teeth subject to the above **Specific Limitations** and **Specific Exclusions** applicable to prefabricated resin crowns for front teeth or prefabricated stainless steel crowns for back teeth. The **Covered Person** is responsible for difference between the **Benefit Amount** for the prefabricated resin crowns for front teeth or prefabricated stainless steel crowns for back teeth and the **Approved Amount** for the **Dental Service** actually rendered.

The **Benefit** for a prefabricated stainless steel crown with resin window or a prefabricated esthetic coated stainless steel crown or a prefabricated resin crown when performed on a posterior primary tooth or a permanent tooth will be determined based on the **Benefit Amount** for a primary or permanent stainless steel crown subject to the above specific **Limitations** and specific **Exclusions** applicable to the **Benefit Amount** for a primary or permanent stainless steel crown. The **Covered Person** is responsible for the difference between the **Benefit Amount** for the primary or permanent stainless steel crown and the **Approved Amount** for the **Dental Service** actually rendered.

Endodontics

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

Deductible	Coverage Percent Paid By Delta Dental (per Coverage Period)			Covered Services
Yes	**1st**	**2nd**	**3rd or more**	Root canal therapy (initial)
	30%	40%	50%	

Specific Limitations

No **Benefits** will be paid for initial root canal treatment: (a) more than once (1) per lifetime per tooth, (b) for primary teeth, (c) if not finished, or (d) when performed **In Conjunction With** apexification.

Endodontics				
Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
Yes	**1st**	**2nd**	**3rd or more**	Pulpotomy, pulpal debridement, and partial pulpotomy for apexogenesis
	30%	40%	50%	

Specific Limitations

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

Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
Yes	**1st**	**2nd**	**3rd or more**	Apexification/recalcification, apicoectomy/periradicular surgery, retrograde fillings, and hemisections on permanent teeth
	30%	40%	50%	

Specific Limitations

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

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

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

Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
Yes	**1st**	**2nd**	**3rd or more**	Retreatment of root canal therapy
	30%	40%	50%	

Specific Limitations

No **Benefit** will be paid for retreatment of root canal treatment: (a) on the same day or within 24 months after the first root canal was finished, or (b) more than once (1) per tooth in a lifetime.

No **Benefit** will be paid for removal of a post, pin(s), old root canal filling material, and the procedures needed to prepare the canals and place the canal filling and root canal therapy when performed **In Conjunction With** endodontic retreatment.

Endodontics
Specific Exclusions & Alternate Treatment Limitations

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

Specific Exclusions

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

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

Alternate Treatment Limitations

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

Periodontics

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

Deductible	Coverage Percent Paid By Delta Dental (per Coverage Period)			Covered Services
Yes	**1st**	**2nd**	**3rd or more**	Periodontal scaling and root planing
	30%	40%	50%	

Specific Limitations

No **Benefit** will be paid for periodontal scaling and root planing: (a) more than once (1) per quadrant on the same day or within twenty-four (24) months, or (b) on the same day or within 30 days before surgery or 90 days following periodontal surgery when performed by the **Same Dentist**.

Scaling and root planing in the absence of 4mm pockets is **Benefited As** a prophylaxis.

Deductible	Coverage Percent Paid By Delta Dental			Covered Services
Yes	**1st**	**2nd**	**3rd or more**	Periodontal maintenance
	30%	40%	50%	

Specific Limitations

No **Benefit** will be paid for periodontal maintenance: (a) more than twice (2) in a 12-month period, (b) when performed on the same day as non-incidental scaling and root planing.

Periodontics

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

No **Benefit** will be paid for any combination of prophylaxes, and periodontal maintenance more than twice (2) in a 12-month period.

Deductible	Coverage Percent Paid By Delta Dental (per Coverage Period)			Covered Services
Yes	**1st**	**2nd**	**3rd or more**	Surgical periodontal treatment, including any surgical re-entry (gingivectomy, osseous surgery, flap surgery, tissue regeneration procedures, distal or proximal wedge, and grafts)
	30%	40%	50%	

Specific Limitations

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

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

No **Benefit** will be paid for apically repositioned flaps, regenerative procedures, soft and connective tissue grafts, and/or osseous grafts when more than two (2) of any combination of these procedures is performed within any given quadrant are performed on the same date of service.

Periodontics
Specific Exclusions & Alternate Treatment Limitations

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

Specific Exclusions

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

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

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

- Osseous surgery
- Clinical crown lengthening (not a **Covered Service**)
- Apically positioned flap
- Surgical revision
- Gingival flap

Periodontics Specific Exclusions & Alternate Treatment Limitations
• Distal or proximal wedge • Anatomical crown exposure • Gingivectomy • Scaling and root planing • Debridement • Periodontal maintenance • Prophylaxis The following **Dental Services** are **Benefited As** quadrants or partial quadrant procedures: • Gingivectomy, scaling and root planing qualify for the full quadrant **Benefit** if four or more diseased teeth distal to the midline are treated. Tooth Bounded Spaces are not counted in making this determination. When these periodontal procedures do not meet all of these criteria they are **Benefited As** a partial quadrant. • Gingival flap procedures and osseous surgery qualify for the full quadrant **Benefit** if four or more diseased teeth or Tooth Bounded Spaces distal to the midline are treated. A Tooth Bounded Space counts as one space despite the number of teeth that would normally exist in the space. When these procedures do not meet all of these criteria the **Benefit** is limited to a partial quadrant. No **Benefit** will be paid for postoperative care and/or finishing procedures (on the same day or within 90 days of periodontal surgery or scaling and root planing). No **Benefit** will be paid for periodontal procedures not performed for natural teeth such as but not limited to being performed **In Conjunction With** ridge augmentation and/or preservation, extraction sites, periradicular surgery. No **Benefit** will be paid for prophylaxis and incidental scaling and root planing procedures by the **Same Dentist** when performed on the same day as periodontal maintenance. No **Benefit** will be paid for prophylaxis and/or periodontal maintenance if the **Dental Services** are performed by the **Same Dentist** during the time period beginning 14 days before and ending 90 days after a scaling and root planing or other periodontal treatment. No **Benefit** will be paid for biologic materials to aid in soft and osseous tissue regeneration on the same day as other periodontal regenerative and grafting procedures except when reported only with gingival flap procedures or osseous surgery. No **Benefit** will be paid for guided tissue regeneration on the same day as soft tissue grafts in the same surgical area. No **Benefit** will be paid for routine prophylaxis (teeth cleaning) when provided **In Conjunction With** periodontal scaling and root planing. No **Benefit** will be paid for periodontal maintenance except after active periodontal therapy (surgical or non-surgical) has been performed.

Prosthodontics – Fixed and Removable

Dental Services to replace missing permanent teeth (not including third molars) where the chewing function is impaired.

Deductible	Coverage Percent Paid By Delta Dental (per Coverage Period)			Covered Services
Yes	**1st**	**2nd**	**3rd or more**	Removable complete and partial dentures
	30%	40%	50%	

Specific Limitations

No **Benefit** will be paid for removable complete and partial dentures: (a) more than once in a 5 7-year period from the date of prior insertion even if **Delta Dental** did not cover the **Patient** and/or pay a **Benefit** toward the prior **Dental Service**, or (b) if the existing denture is satisfactory or can be made satisfactory.

No **Benefit** will be paid for removable partial dentures with cast metal framework for **Patients** under age 16.

Deductible	Coverage Percent Paid By Delta Dental (per Coverage Period)			Covered Services
Yes	**1st**	**2nd**	**3rd or more**	Fixed partial dentures (bridges), including retainers (crowns) pontics, core buildups, and post and cores
	30%	40%	50%	

Specific Limitations

No **Benefit** will be paid for fixed partial dentures (bridges), including retainers (crowns) pontics, core buildups, and post and cores: (a) more than once (1) in a 7-year period from the date of prior insertion, or (b) if the existing fixed partial denture is satisfactory or can be made satisfactory.

No **Benefit** will be paid for core buildups when performed **In Conjunction With** restorations, inlays, onlays, or post and core of any type.

Deductible	Coverage Percent Paid By Delta Dental (per Coverage Period)			Covered Services
Yes	**1st**	**2nd**	**3rd or more**	Adjustments, repairs, relines, rebases and tissue conditioning to removable complete and partial dentures
	30%	40%	50%	

Specific Limitations

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

No **Benefit** will be paid for any combination of repairs, relines, rebases, and tissue conditioning more than twice (2) per denture unit on the same day or within 12 months.

No **Benefit** will be paid for adjustments: (a) when performed by the **Same Dentist** on the same day or within 6 months of a reline or rebase, (b) more than once (1) on the same day, or (c) more than twice (2) within 12 months.

No **Benefit** will be paid for a reline when performed by the **Same Dentist** on the same day or within six months of a rebase. No **Benefit** will be paid for tissue conditioning if performed on the same date of service as the denture is delivered or a reline/rebase is delivered.

Prosthodontics – Fixed and Removable				
Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
Yes	**1st**	**2nd**	**3rd or more**	Recementation of fixed partial dentures (bridges)
	30%	40%	50%	

Specific Limitations

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

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

Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
Yes	**1st**	**2nd**	**3rd or more**	Repair of fixed partial dentures (bridges)
	30%	40%	50%	

Specific Limitations

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

Prosthodontics – Fixed and Removable
Specific Exclusions & Alternate Treatment Limitations

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

Specific Limitations

For purposes of determining frequency limitations; implant supported or natural tooth inlays; onlays; indirectly fabricated crowns; veneers; fixed partial dentures; removable partial dentures; immediate and complete dentures are counted against themselves and each other.

Specific Exclusions

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

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

Prosthodontics – Fixed and Removable Specific Exclusions & Alternate Treatment Limitations
The maximum **Benefit Amount** that will be paid for repair, and/or reline, and/or rebase, and/or adjustment of a fixed or removable partial denture or complete denture or combination exceeds is one-half the **Benefit Amount** that would be payable under this **Policy** for a new appliance. The maximum **Benefit Amount** that will be paid for replacing all teeth and acrylic on a cast metal removable partial denture framework is two-thirds the **Benefit Amount** that would be payable under this **Policy** for a new appliance. No **Benefit** will be paid for repair of a fixed partial denture if the payment would exceed one-half of the **Benefit** that would be payable under this **Policy** for a new appliance. No **Benefit** will be paid for implants or any procedures, restorations, appliances and/or crown and fixed partial denture associated with periodontal splinting. No **Benefit** will be paid for a (posterior) fixed partial denture if performed **In Conjunction With** an Allowance for a partial denture in the same arch within the preceding 57-year period. No **Benefit** will be paid for fixed partial dentures bridges and removable cast partial dentures for **Patients** less than sixteen 16 years of age. **Alternate Treatment Limitations** No **Benefit** will be paid for a fixed partial denture unless use of a removable prosthetic device is not sufficient. If a removable device is sufficient, the **Benefit** will be determined based on the **Benefit Amount** for a standard removable partial denture subject to the above **Specific Limitations** and **Specific Exclusions** applicable to a standard removable partial denture. The **Covered Person** is responsible for the difference between the **Benefit Amount** for the standard removable partial denture and the **Approved Amount** for the **Dental Service** actually rendered. When more than three teeth (except third molars) are missing in an arch, the **Benefit** for a fixed partial denture will be determined based on the **Benefit Amount** for a removable partial denture subject to the above **Specific Limitations** and **Specific Exclusions** applicable to a standard removable partial denture. The **Covered Person** is responsible for the difference between the **Benefit Amount** for the removable partial denture and the **Approved Amount** for the **Dental Service** actually rendered. The **Benefit Amount** for personalized restoration, specialized techniques, such as but not limited to precision attachments, overdentures, and stress breakers as opposed to standard procedures will be determined based on the **Benefit Amount** for the standard procedure subject to the **Specific Limitations** and **Specific Exclusions** applicable to the standard procedure. The **Covered Person** is responsible for the difference between the **Benefit Amount** for the standard procedure and the **Approved Amount** for the **Dental Service** actually rendered. The **Benefit Amount** for an indirect resin-based composite or porcelain-ceramic fixed partial denture will be determined based on the **Benefit Amount** for the porcelain fused to high noble metal fixed partial denture subject to the **Specific Limitations** and **Specific Exclusions** applicable to the porcelain fused to high noble metal fixed partial denture. The **Covered Person** is responsible for the difference between the **Benefit Amount** for the porcelain fused to high noble metal fixed partial denture and the **Approved Amount** for the **Dental Service** actually rendered.

Oral Surgery

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

Deductible	Coverage Percent Paid By Delta Dental (per Coverage Period)			Covered Services
Yes	**1st**	**2nd**	**3rd or more**	Non-surgical and surgical extraction of teeth Intraoral incision and drainage
	30%	40%	50%	

Specific Limitations

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

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

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

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

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

Extractions of impacted teeth are **Benefited As** determined by the anatomical position of the tooth rather than the surgical procedure necessary for removal.

Deductible	Coverage Percent Paid By Delta Dental (per Coverage Period)			Covered Services
Yes	**1st**	**2nd**	**3rd or more**	Alveoloplasty Biopsy, brush biopsy (collection of sample only – does not include lab analysis) Removal of exostosis and tori; fibrous tuberosity reduction, Suture of small wounds, frenulectomy, frenuloplasty, excision of pericoronal and hyperplastic tissue Uncomplicated vestibuloplasty
	30%	40%	50%	

Specific Limitations

No **Benefit** will be paid for alveoloplasty when performed on the same date of service as one or more surgical extractions.

No **Benefit** will be paid for biopsy of oral tissue: a) without a pathology report, or b) when performed by the **Same Dentist** in the same surgical area on the same date of service as a surgical procedure (e.g., apicoectomy, extractions, etc.).

No **Benefit** will be paid for frenulectomy, frenuloplasty, excision of hyperplastic tissue, and excision of pericoronal gingiva when performed by the **Same Dentist** in the same surgical area on the same date as any other surgical procedure(s).

Oral Surgery				
Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
Yes	**1st**	**2nd**	**3rd or more**	General anesthesia when administered in a dental office by a **Dentist** licensed to perform this **Service**
	30%	40%	50%	
Specific Limitations No **Benefit** will be paid for general anesthesia or intravenous sedation: (a) unless medically necessary **In Conjunction With** oral surgical procedures, periodontal surgery, or periapical surgery that are **Covered Services**, or unless necessary due to concurrent medical conditions, and/or (b) to the extent it exceeds 1.5 hours per date of service.				

Oral Surgery
Specific Exclusions & Alternate Treatment Limitations

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

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

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

Adjunctive General Services Other **Dental Services**				
Deductible	**Coverage Percent Paid By Delta Dental (per Coverage Period)**			**Covered Services**
Yes	**1st**	**2nd**	**3rd or more**	Palliative treatment Fixed partial denture sectioning Treatment of unusual post-surgical complications
	30%	40%	50%	
Specific Limitations No **Benefit** will be paid for Palliative treatment: (a) when any **Dental Service** other than limited radiographs, tests, evaluations, consults, and visits necessary to diagnose the emergency condition is performed by the **Same Dentist** on the same date, or (b) more than once (1) per date of service and/or c), more than 4 within a 12-month period. No **Benefit** will be paid for fixed partial denture sectioning when performed **In Conjunction With** removing and replacing a fixed prosthesis. No **Benefit** will be paid for routine post-operative care, routine post-operative radiographs, and routine post-operative evaluations when performed by the **Same Dentist** as rendered the operative care.				

Adjunctive General Services

Other **Dental Services**

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

Deductible	Coverage Percent Paid By Delta Dental (per Coverage Period)			Covered Services
Yes	**1st**	**2nd**	**3rd or more**	Consultations
	30%	40%	50%	

Specific Limitations

No **Benefit** will be paid for consultations: (a) when performed by the **Same Dentist In Conjunction With** an exam or oral evaluation, (b) when performed in connection with **Dental Services** that are not **Covered Services**, or (c) when the **Dental Service** is provided by a **Dentist** whose opinion or advice about an evaluation and/or caring for of a specific problem is not requested by another **Dentist**, physician, or appropriate entity.

No **Benefit** will be paid for dental consultations and evaluations of any type when any combination of these procedures is performed more than twice (2) in a 12-month period.

Deductible	Coverage Percent Paid By Delta Dental (per Coverage Period)			Covered Services
Yes	**1st**	**2nd**	**3rd or more**	General anesthesia and IV sedation
	30%	40%	50%	

Specific Limitations

No **Benefit** will be paid for general anesthesia or intravenous sedation: (a) unless medically necessary **In Conjunction With** covered oral surgical procedures, periodontal surgery, or periapical surgery, or unless necessary due to concurrent medical conditions, and/or (b) to the extent it exceeds 1.5 hours per date of service.

No **Benefit** will be paid for intravenous sedation when the drug is not administered intravenously to achieve sedation.

Adjunctive General Services
Specific Exclusions & Alternate Treatment Limitations

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

Specific Exclusions

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

- Anesthesia: local; regional and trigeminal block; analgesia; anxiolysis; nitrous oxide; non-intravenous conscious sedation
- Professional visits: house, hospital and ambulatory surgical center calls; office visits; hospitalization costs; case presentation and treatment planning
- Drugs: euphoric or prescription drugs, or writing prescriptions, therapeutic parenteral drugs, or other drugs or medicaments
- Miscellaneous: desensitizing procedures, behavior management, occlusal guard, repair, reline and adjustment of occlusal guard, athletic mouthguards, occlusal analysis including mounted case, occlusal adjustment, enamel microabrasion, odontoplasty, internal and external bleaching

Adjunctive General Services Specific Exclusions & Alternate Treatment Limitations
• Anesthesia and/or IV sedation time before the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol. • Anesthesia and/or IV sedation time after the **Patient** may be safely left under the observation of trained personnel and the doctor may safely leave the room to look after other patients or duties.

8.0 - GENERAL EXCLUSIONS (Applicable To All Dental Services)

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

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

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

    a. **Dental Services** not specifically listed as **Covered Services** in Section 7.0 of this **Policy**, including but not limited to orthodontic services, maxillofacial prosthetics, implants and any services associated with implants.

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

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

    d. **Dental Services** for injuries or conditions which are compensable under Workmen's Compensation or Employer's Liability laws; **Dental Services** which are provided by any Federal or State or Provincial government agency or are provided without cost to the **Covered Person** by any municipality, county, or political subdivision or community agency, except to the extent such payments are not enough to pay the **Approved Amount** therefor.

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

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

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

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

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

j. **Dental Services** of a trial, experimental or investigational nature that do not meet professionally recognized standards of dental practice or have not been shown to be consistently effective for the diagnosis or treatment of the condition, disease, or injury of the **Covered Person.**

k. Charges for hospitalization, including hospital visits.

l. Exploratory surgery or unsuccessful attempts at extractions.

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

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

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. 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 **Covered Person's** condition, disease or injury. Some dental services have age restrictions and may not be benefited due to **Delta Dental** processing policies that are based on recognized community standards. **Dental Services** that do not prevent, evaluate, diagnose, or treat a dental condition, disease or injury and that we determine are not in accordance with generally accepted standards of dental practice, are not clinically appropriate in terms of type, frequency, extent, site, and duration, are not effective for the **Covered Person's** condition, disease, or injury, or are more costly than an alternative service that is at least likely to produce the same benefit or diagnostic result. **Delta Dental** reserves the right to check the **Covered Person's** dental records; this includes but is

not limited to necessary radiographs; oral facial images; models, and financial records to decide whether a **Dental Service** or item meets these criteria.

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

r. Broken appointments.

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

t. Periodontal charting.

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

v. 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. 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**.

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

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

y. Onlays, crowns, prosthetic retainers, and pontics post and cores, and core buildups are limited to one per tooth per 84 months without regard to whether the tooth has been sectioned.

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

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

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

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

dd. Myofunctional therapy.

ee. **Dental Services** to correct developmental or congenital malformations, replace or repair teeth due to such conditions; procedures, appliances, or restorations for cosmetic purposes; procedures, appliances, or restorations to increase vertical dimension; restore occlusion; or repair tooth structure lost by attrition; erosion; corrosion; abfraction; or related to bruxism; TMJ; TMD; or occlusal equilibration, occlusal analysis and mounted case analysis, or occlusal adjustment.

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.

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

jj. Complications of non-covered services.

kk. Grafts provided for other reasons such as filling in an extraction site or a defect resulting from an apicoectomy.

9.0 – OTHER PAYMENT RULES THAT AFFECT YOUR COVERAGE

Delta Dental will pay a **Benefit** for only those **Dental Services** that are **Covered Services**. Not all **Dental Services** are covered under this **Policy**. **Delta Dental** will not pay a **Benefit** unless **You** are enrolled on the start and **Completion Date** of the **Dental Services**. **Benefits** are determined based on the date **Dental Services** are finished.

9.1 – Dental Services Requiring Multiple Visits
Some **Dental Services** take multiple visits to complete. Examples include crowns, bridges, removable prosthetics, and endodontic procedures. **Delta Dental** pays for **Covered Services** that need multiple visits only upon completion of the **Dental Services**. The **Completion Date** is deemed to be the date of service for these **Dental Services**.

9.2 - In-Process Treatment
Dental Services started before **Your Coverage Effective Date** under this **Policy** are not entitled to any **Benefit**. Examples of the **Dental Services** which may be performed over more than one visit include, but are not limited to fixed bridgework, full or partial dentures, crowns, and root canal therapy. The **Completion Date** of these **Dental Services** must occur before the **Coverage Expiration Date** in order for them to be due any **Benefit** under this **Policy**. The **Completion Date** is the date of insertion for removable prosthetic appliances; the insertion date for fixed partial dentures and for crowns; onlays; and inlays; is the cementation date no matter what the type of cement used. The **Completion Date** for root canal therapy is the date the canals are permanently filled.

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

9.4 – Dental Services Covered Under a Medical Policy
To sign up for this **Policy**, **You** or **Your Dependents** cannot be covered under another dental policy. But, **You** may have medical coverage for **You** and/or **Your Dependents**. **Your** medical policy may cover certain **Dental Services** such as oral surgery which is a **Covered Service** under this **Policy**.

10.0 – PRE-TREATMENT ESTIMATES, CLAIMS, AND APPEALS

10.1 - Pre-Treatment Estimate
A **Dentist** may send a **Claim** to **Delta Dental** showing the **Dental Services** he or she recommends for **You**. **Delta Dental** will then provide an estimate of **Benefits** under **Your Policy**. **We** call this a **Pre-Treatment Estimate**. **You do not need** prior approval of **Dental Services** under this **Policy**. The **Benefit Amount** for these **Dental Services** will depend on Eligibility, and any **Benefit Limitations** and **Exclusions**. If **Your Dentist** suggests the need for **Dental Services** which cost more than $300, ask for a **Pre-Treatment Estimate** before receiving the **Dental Services**.

10.2 - Filing a Claim
The following is a description of how a **Claim** is processed. If **You** use a **Delta Dental Participating Dentist**, the **Dentist** will send a **Claim** on **Your** behalf. If **You** visit a **Non-Participating Dentist**, **You** or the **Connecticut Non-Participating Dentist** must send the **Claim**. In other states, **You** may need to send the **Claim Yourself** for **Dental Services** performed by a **Non-Participating Dentist**. **Claim** forms must be sent to:

Delta Dental of Connecticut, Inc.
c/o Wyssta Services, Inc.
P.O. Box103
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 **You** or **Your Dentist** within twelve (12) months of the date **Dental Services** are completed. **Delta Dental** must approve the **Claim**, deny the **Claim**, or ask for more information within the time frames prescribed by law and/or regulation.

10.3 - Any **Benefit** that **We** pay for **Covered Services** rendered by a **Non-Participating Dentist** shall be issued to **You** unless **You** assign benefits in writing to the dentist no later than the time of filing the **Claim** and **We** shall 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 **Your Claim**.

10.4 - 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**;

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

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

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

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

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

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

10.6 - 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:

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

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

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

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

10.7 - 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:

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

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The request for a formal review must include the following:

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

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

10.8 - 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.

10.9 - 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.

You may contact the Connecticut Insurance Department with a complaint or regarding an appeal at:

Connecticut Insurance Department
P.O. Box 816
Hartford, Ct 06142-0816
Telephone: 1-860-297-3800
1-800-203-3447

10.10 – Limitations on Legal Action
You must timely file an **Adverse Benefit Determination** appeal and get **Our** decision as described in Sections 10.3, 10.4, 10.5, 10.6, 10.7, and 10.8 above before commencing any legal proceeding challenging any **Adverse Benefit Determination**. In any event, no legal proceeding shall be brought against **Delta Dental** for any determination once 36 months have passed from the date of when **Dental Services** were performed.

10.11 - 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.

10.12 - 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 1-888-696-3262 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 Connecticut.

11.2 – Assignment of Benefits
When **You** receive **Covered Services** from a **Delta Dental Participating Dentist, We** will make payment of **Benefits** directly to the **Delta Dental Participating Dentist**. If **You** receive **Covered Services** from a **Non-Participating Dentist,** we may choose to make payment of **Benefits** either directly to **You** or to the **Non-Participating Dentist.** To the extent permitted by law, we will not accept an assignment of **Your** rights under this **Policy** to a **Non-Participating Dentist** or any third party.

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

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

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

11.6 - Time Limit on Certain Defenses
A fraudulent statement made by **You** in any application for this **Policy** will entitle **Delta Dental** to terminate this **Policy**. No statement made by the **Subscriber** in the application will be used to terminatethis **Policy** or be used in any legal proceeding unless the application or an exact copy is included with or attached to this **Policy**.

11.7 - Overpayments
Delta Dental has the right to get back any payment made to a **Subscriber**, **Covered Person**, or **Dentist** which is more than the amount the person was entitled to get under this **Policy** or if the Payment was made to the wrong payee, **Delta Dental** may offset any such overpayment against any amount which otherwise is due to **You** under this **Policy**. If we cannot recover the overpayment from the person we paid – **You** or **Your Dentist** – we have the right to reduce any future **Benefit** payment by the amount of the overpayment.

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:

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

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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 and shall not be affected, impaired, or invalidated as a result of such ruling.

11.12 – Dentists as Independent Licensees

Delta Dental shall make payment for **Dental Services** in accordance with the terms of this **Policy** and applicable law. The **Dentist You** consult with or select for treatment is not an agent or employee of **Delta Dental. Delta Dental** shall not be liable for any injury to a **Covered Person** as a result of services by a **Dentist** or others employed or engaged by a **Dentist.**

11.13 - Compliance with Laws and Regulations

If a provision of this **Policy** violates federal or state law, including, but not limited to, the applicable health care privacy and disclosure provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) it shall be unenforceable and the remaining terms shall constitute the **Policy**. If this **Policy**, or any part of it, is not in compliance with applicable federal or state law, then **Delta Dental** shall administer this **Policy** in accordance with the applicable federal or state law and amend the **Policy** to correct the noncompliance.

11.14 - Confidentiality of Your Information

Delta Dental is a "Covered Entity" under the rules of HIPAA. **We** use and share **Your** information to process claims and manage **Your Policy** and will comply with all applicable privacy and security rules of HIPAA and applicable State law about the protected health information of **Covered Persons**. This provision shall survive the termination of the **Policy**. **You** can get a copy of **Delta Dental's** Notice of Privacy Practices at www.deltadentalcoversme.com.

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.

11.16 – Dental Examinations, Evaluations, and Information

Delta Dental has the right to request information or examinations reasonably related to **Your** claim for **Benefits** under this **Policy**. **We** may also have a **Dentist** of our choice examine **You** in connection with a claim for **Benefits**.

Delta Dental of Connecticut, Inc.
P.O. Box 16354
Little Rock, AR 72231

Individual Dental Policy – **Progressive Plan**
FORM DDCT-IND-STEP-2019 – PPO SPEC 2021