Delta Dental PPO℠
Our national PPO program

Welcome!

Delta Dental Plan of Ohio, Inc. is a nonprofit health-insuring corporation doing business as Delta Dental of Ohio. Delta Dental of Ohio is the state's dental benefits specialist. Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Certificate, along with your Summary of Dental Plan Benefits, describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call our Customer Service department at (800) 524-0149 or access our website at www.DeltaDentalOH.com.

You can easily verify your own benefit, claims and eligibility information online 24 hours a day, seven days a week by visiting www.DeltaDentalOH.com and selecting the link for our Consumer Toolkit. The Consumer Toolkit will also allow you to print claim forms and ID cards, select paperless Explanation of Benefits statements (EOBs), search our Dentist directories, and read oral health tips.

We look forward to serving you!

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Please read this Certificate together with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of your group dental plan. If a statement in the Summary conflicts with a statement in this Certificate, the statement in the Summary applies to This Plan and you should ignore the conflicting statement in this Certificate.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE AND/OR DENTAL CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DENTISTS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

I. Delta Dental PPO Certificate

Delta Dental Plan of Ohio, Inc., referred to herein as Delta Dental, issues this Certificate to you, the Subscriber. The Certificate is a summary of your dental benefits coverage. It reflects and is subject to a contract between Delta Dental and your employer or organization.

The Benefits provided under This Plan may change if any state or federal laws change. Delta Dental agrees to provide Benefits as described in this Certificate and the Summary of Dental Plan Benefits. All the provisions in the following pages form a part of this document as fully as if they were stated over the signature below.

IN WITNESS WHEREOF, this Certificate is executed at Delta Dental's home office by an authorized officer.

Laura L. Czelada, CPA, President and CEO
Delta Dental Plan of Ohio, Inc.

II. Definitions

Adverse Benefit Determination Any denial, reduction or termination of the benefits for which you filed a claim. Or a failure to provide or to make payment (in whole or in part) of the benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational, or was not medically necessary or appropriate.

Benefit Year The calendar year, unless your employer or organization elects a different period to serve as the Benefit Year. (See the Summary of Dental Plan Benefits for your Benefit Year.)

Benefits Payment for the Covered Services that have been selected under This Plan.

Certificate This document. Delta Dental will provide Benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the contract between Delta Dental and your employer or organization.

Children or Child Your natural Children, stepchildren, adopted Children, Children by virtue of legal guardianship, or Children who are residing with you during the waiting period for adoption or legal guardianship.

Completion Dates The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;
- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Control Plan (Delta Dental) Delta Dental acts as the Control Plan for your contract. The Control Plan will provide all claims processing, service, and administration for your group. The Control Plan is referred to as Delta Dental in this document.

Copayment The percentage of the charge, if any, that you must pay for Covered Services.

Covered Services The unique dental services selected for coverage as described in the Summary of Dental Plan Benefits and subject to the terms of this Certificate.

Deductible The amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

Delta Dental Delta Dental Plan of Ohio, Inc., a nonprofit health-insuring corporation providing dental benefits. Delta Dental is not an insurance company.

Delta Dental Plan An individual dental benefit plan that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

Delta Dental PPO Delta Dental's national preferred provider organization program that can reduce your out-of-pocket expenses if you receive care from a Delta Dental PPO Dentist.

Delta Dental Premier Delta Dental's national managed fee-for-service dental benefits program.

Dentist A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

- **Delta Dental PPO Dentist ("PPO Dentist")** – a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental PPO.
- **Delta Dental Premier Dentist ("Premier Dentist")** – a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental Premier.
- **Nonparticipating Dentist** – a Dentist who has not signed an agreement with any Delta Dental Plan to participate in Delta Dental PPO or Delta Dental Premier.
- **Out-of-Country Dentist** – A Dentist whose office is located outside the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

PPO Dentists and Premier Dentists are sometimes collectively referred to herein as **"Participating Dentists."** Wherever a definition or provision of this Certificate differs from another state's Delta Dental Plan and its agreement with Participating Dentists, the agreement in that state with that Dentist will be controlling.

Premier Dentists, Nonparticipating Dentists, and Out-of-Country Dentists are sometimes collectively referred to herein as **"Non-PPO Dentists."**

Eligible Dependent(s) The Summary of Dental Plan Benefits will have specific information about This Plan's rules for dependent eligibility, but generally, your Eligible Dependents are:

- Your legal spouse
- Your unmarried Children who have not yet reached the dependent age limit stated in the Summary of Dental Plan Benefits
- Your unmarried Children who have reached the dependent age limit stated in the Summary of Dental Plan Benefits, but are eligible to be claimed by you as dependents under the U.S. Internal Revenue Code during the current calendar year
- Any unmarried Children for whom you or your legal spouse are financially responsible for the medical, health, or dental care under the terms of a court decree or who have been named as alternate recipients under a qualified medical child support order
- Your Children who have reached the dependent age limit stated in the Summary of Dental Plan Benefits, but who

were at that time (and continue to be) totally and permanently disabled by a physical or mental condition. Those Children must also be eligible to be claimed by you or your legal spouse as dependents under the U.S. Internal Revenue Code during the current calendar year. If Delta Dental asks you to do so, you must submit medical reports confirming the Child's initial or continuing total disability.

Eligible Person(s) Any Subscriber or Eligible Dependent with coverage under This Plan.

Maximum Approved Fee A system used by Delta Dental to determine the approved fee for a given procedure for a given Participating Dentist. A fee meets Maximum Approved Fee requirements if it is the lowest of:

- The Submitted Amount
- The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service or supply, irrespective of the Dentist's contractual agreement with another dental benefits organization.
- The maximum fee that the local Delta Dental Plan approves for a given procedure in a given region and/or specialty, under normal circumstances, based upon applicable Participating Dentist schedules and internal procedures.

Delta Dental may also approve a fee under unusual circumstances. Participating Dentists agree not to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Payment The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. (See the Summary of Dental Plan Benefits.)

Nonparticipating Dentist Fee The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist as determined by Delta Dental.

Open Enrollment Period The period of time, as determined by your employer or organization, during which an Eligible Person may enroll or be enrolled for Benefits.

Out-of-Country Dentist Fee The maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist as determined by Delta Dental.

Post-Service Claims Claims for Benefits that are not conditioned on your seeking advance approval, certification, or authorization to receive the full amount for any Covered Services. In other words, Post-Service Claims arise when you receive the dental service or treatment before you file a claim for Benefits.

PPO Dentist Schedule The maximum fee allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Plan.

Premier Dentist Schedule The maximum fee allowed per procedure for services rendered by a Premier Dentist as determined by that Dentist's local Delta Dental Plan.

Pre-Treatment Estimate A voluntary and optional process where Delta Dental issues a written estimate of dental benefits that may be available under your coverage for your proposed dental treatment. Your Dentist submits the proposed dental treatment to Delta Dental in advance of providing the treatment.

A Pre-Treatment Estimate is for informational purposes only and is not required before you receive any dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same Benefits under This Plan whether or not a Pre-Treatment Estimate is requested. The benefits estimate provided on a Pre-Treatment Estimate notice is based on benefits available on the date the notice is issued. It is not a guarantee of future dental benefits or payment.

Availability of dental benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, This Plan's limitations and any other provisions, together with any additional information or changes to your dental treatment. A request for a Pre-Treatment Estimate is not a claim for Benefits or a preauthorization, precertification or other reservation of future Benefits.

Processing Policies Delta Dental's policies and guidelines used for Pre-Treatment Estimate and payment of claims. The Processing Policies may be amended from time to time.

Submitted Amount The amount a Dentist bills to Delta Dental for a specific treatment or service. A Participating Dentist cannot charge you or your Eligible Dependents for the difference between this amount and the amount Delta Dental approves for the treatment.

Subscriber You, when your employer or organization notifies Delta Dental that you are eligible to receive Benefits under This Plan.

Summary of Dental Plan Benefits A description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate, and supersedes any contrary provision of this Certificate.

This Plan The dental coverage established for Eligible Persons pursuant to this Certificate.

III. Selecting a Dentist

You may choose any Dentist. Your out-of-pocket costs are likely to be less if you go to a Delta Dental Participating Dentist. To verify that a Dentist is a Participating Dentist, you can use Delta Dental's online Dentist Directory at www.DeltaDentalOH.com or call (800) 524-0149.

IV. Accessing Your Benefits

To utilize your dental benefits, follow these steps:

1. Please read this Certificate and the Summary of Dental Plan Benefits carefully so you are familiar with your benefits, payment methods, and terms of This Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits with Delta Dental. If your Dentist is not familiar with This Plan or has any questions, have him or her contact Delta Dental by writing to Delta Dental, Attention: Customer Service, PO Box 9089, Farmington Hills, Michigan 48333-9089, or calling the toll-free number at (800) 524-0149.
3. After you receive your dental treatment, you or the dental office staff will file a claim form, completing the information portion with:
    a. The Subscriber's full name and address

b. The Subscriber's Member ID number
c. The name and date of birth of the person receiving dental care
d. The group's name and number

Notice of Claim Forms Delta Dental does not require special claim forms. However, most dental offices have claim forms available. Participating Dentists will fill out and submit your dental claims for you. Mail claims and completed information requests to: **Delta Dental, PO Box 9085, Farmington Hills, Michigan 48333-9085.**

Pre-Treatment Estimate A Pre-Treatment Estimate is not required to receive payment, but it allows claims to be processed more efficiently and allows you to know what services may be covered before your Dentist provides them. You and your Dentist should review your Pre-Treatment Estimate Notice before treatment. Once treatment is complete, the dental office will submit a claim to Delta Dental for payment.

Written Notice of Claim and Time of Payment Because the amount of your Benefits is not conditioned on a Pre-Treatment Estimate decision by Delta Dental, all claims under This Plan are Post-Service Claims. All claims for Benefits must be filed with Delta Dental within one year of the date the services were completed. Once a claim is filed, Delta Dental will decide it within 30 days of receiving it. If there is not enough information to decide your claim, Delta Dental will notify you or your Dentist within 30 days. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the claim, and (d) inform you or your Dentist that the information must be received within 45 days or your claim will be denied. You will receive a copy of any notice sent to your Dentist. Once Delta Dental receives the requested information, it has 15 days to decide your claim. If you or your Dentist does not supply the requested information, Delta Dental will have no choice but to deny your claim. Once Delta Dental decides your claim, it will notify you within five days.

Authorized Representative You may also appoint an authorized representative to deal with Delta Dental on your behalf with respect to any benefit claim you file or any review of a denied claim you wish to pursue (see the Claims Appeal Procedure section). You should contact your Human Resources department, call Delta Dental's Customer Service department, toll-free, at (800) 524-0149, or write them at PO Box 9089, Farmington Hills, Michigan, 48333-9089, to request a form to designate the person you wish to appoint as your representative. While in some circumstances your Dentist is treated as your authorized representative, generally Delta Dental only recognizes the person whom you have authorized on the last dated form filed with Delta Dental. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not inform you of the status of your claim. You will have to get that information from your representative. If you have not designated a representative, Delta Dental will communicate directly with you.

Questions and Assistance Questions regarding your coverage should be directed to your Human Resources department or call Delta Dental's Customer Service department, toll-free, at (800) 524-0149. You may also write to Delta Dental's Customer Service department at PO Box 9089, Farmington Hills, Michigan, 48333-9089. When writing to Delta Dental, please include your name, the group's name and number, the Subscriber's Member ID number, and your daytime telephone number.

V. How Payment is Made

Delta Dental shall make payments for covered services in accordance with the plan selected by your employer or organization. Your Plan will be identified on your Summary of Dental Plan Benefits.

Delta Dental PPO (Point-of-Service)

If your Dentist is a Participating Dentist, Delta Dental will base payment on the Maximum Approved Fee for Covered Services.

Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Copayments or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

If your Dentist is a Nonparticipating Dentist, Delta Dental will base payment on the Nonparticipating Dentist Fee for Covered Services. If your Dentist is an Out-of-Country Dentist, Delta Dental will base payment on the Out-of-Country Dentist Fee for Covered Services. For Covered Services rendered by a Nonparticipating Dentist or Out-of-Country Dentist, Delta Dental will usually send payment to you, and you will be responsible for making full payment to the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

Delta Dental PPO (Standard)

Whether your Dentist is a PPO Dentist or not, Delta Dental will base its payment on the lesser of the Submitted Amount or the PPO Dentist Schedule.

Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Copayments or Deductibles. If your Dentist is not a PPO Dentist, but is a Premier Dentist, you will also be responsible for any difference between the PPO Dentist Schedule and the Premier Dentist Schedule for Covered Services, in addition to Copayments or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

For Covered Services rendered by a Nonparticipating Dentist or Out-of-Country Dentist, Delta Dental will usually send payment to you, and you will be responsible for making full payment to the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

VI. Benefit Categories

Important: **A description of various dental services that can be selected for dental benefits is included below.** ONLY the dental services listed in your Summary of Dental Plan Benefits are covered by This Plan**. Covered Services are also subject to exclusions and limitations. You will want to review this section of this Certificate carefully.**

Diagnostic & Preventive

Diagnostic and Preventive Services Services and procedures to determine your dental health or to prevent or reduce dental disease. These services include examinations, evaluations, prophylaxes (cleanings), space maintainers, and fluoride treatments.

Brush Biopsy Oral brush biopsy procedure and laboratory analysis used to detect oral cancer. Using this diagnostic procedure, Dentists can identify and treat abnormal cells that could become cancerous, or they can detect the disease in its earliest and most treatable stage.

Radiographs X-rays as required for routine care or as needed to diagnose the condition of your teeth.

Emergency Palliative Treatment Emergency treatment to temporarily relieve pain.

Basic Services

Oral Surgery Services Extractions and dental surgery, including pre-operative and post-operative care.

Endodontic Services The treatment of teeth with diseased or damaged nerves (for example, root canals).

Periodontic Services The treatment of diseases of the gums and supporting structures of the teeth, including periodontal maintenance following periodontal therapy.

Relines and Repairs Relines and repairs to partial dentures and complete dentures, and repairs to bridges.

Restorative Services Services to rebuild and repair your teeth damaged by disease, decay, fracture, or injury.

Restorative services include:

- ♦ Minor restorative services, such as amalgam (silver) fillings and composite resin (white) fillings.
- ♦ Major restorative services, such as crowns, used when teeth cannot be restored with another filling material.

Major Services

Prosthodontic Services Services and appliances that replace missing natural teeth (such as bridges, endosteal implants, partial dentures, and complete dentures).

Orthodontic Services

Services, treatment, and procedures to correct malposed or misaligned teeth (such as braces).

Other Benefits

The Summary of Dental Plan Benefits lists any other Benefits that may have been selected.

VII. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the same will be your responsibility (though your payment obligation may be satisfied by insurance or some other arrangement for which you are eligible):

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX of the Social Security Act; that is, Medicaid.
2. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
4. Services started or appliances started before a person became eligible under This Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
5. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
6. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
7. Charges for hospitalization, laboratory tests, and histopathological examinations.
8. Charges for failure to keep a scheduled visit with the Dentist.
9. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
10. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
11. Services or supplies, as determined by Delta Dental, which are specialized techniques.
12. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
13. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist or other dental professional, as determined by Delta Dental, under the scope of his or her license as permitted by applicable state law.
14. Services or supplies excluded by the policies and procedures of Delta Dental, including the Processing Policies.
15. Services or supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
16. Services or supplies received due to an act of war, declared or undeclared.
17. Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
18. Services or supplies that are not within the categories of Benefits covered under the terms of this Certificate and the Summary of Dental Plan Benefits.
19. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
20. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
21. Sealants.
22. Space maintainers for maintaining space due to premature loss of anterior primary teeth.
23. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
24. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
25. Veneers.

26. Prefabricated crowns used as final restorations on permanent teeth.
27. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of this Certificate and the Summary of Dental Plan Benefits.
28. Paste-type root canal fillings on permanent teeth.
29. Replacement, repair, relines, or adjustments of occlusal guards.
30. Chemical curettage.
31. Services associated with overdentures.
32. Metal bases on removable prostheses.
33. The replacement of teeth beyond the normal complement of teeth.
34. Personalization or characterization of any service or appliance.
35. Temporary crowns used for temporization during crown or bridge fabrication.
36. Posterior bridges in conjunction with partial dentures in the same arch.
37. Precision attachments and stress breakers.
38. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
39. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint.
40. Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.
41. Myofunctional therapy.
42. Mounted case analyses.

Delta Dental will make no payment for the following services or supplies. Participating Dentists may not charge Eligible Persons for these services or supplies. All charges from Nonparticipating Dentists for the following are your responsibility:

1. The completion of forms or submission of claims.
2. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
3. Local anesthesia.
4. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
5. Infection control.
6. Temporary, interim, or provisional crowns.
7. Gingivectomy as an aid to the placement of a restoration.
8. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
9. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
10. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
11. Post-operative X-rays, when done following any completed service or procedure.
12. Periodontal charting.
13. Pins and preformed posts, when done with core buildups for crowns, onlays, or inlays.
14. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
15. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
16. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
17. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
18. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling and root planing.
19. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
20. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
21. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental Plan or, at the request of your group, any dental plan:

1. Bitewing X-rays are payable once per calendar year. Panoramic or full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
2. Any combination of teeth cleanings (prophylaxes, full mouth debridement and periodontal maintenance procedures) are payable twice per calendar year. Full mouth debridement is payable only once in a lifetime.
3. Oral examinations and evaluations are only payable twice per calendar year, regardless of the Dentist's specialty.
4. Patient screening is payable once per calendar year.
5. Preventive fluoride treatments are payable twice per calendar year for people under age 19.
6. Space maintainers are payable for people under age 14.
7. Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth.
8. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture.
9. Individual crowns over implants are payable at the prosthodontic benefit level.
10. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people under age 12.
11. An occlusal guard is payable once in a lifetime.

12. An interim partial denture is payable only for the replacement of permanent anterior teeth for people under age 17 or during the healing period for people age 17 and over.
13. Prosthodontic Services limitations:
    a. One complete upper and one complete lower denture are payable once in any five-year period.
    b. A removable partial denture, implant, or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
    c. Fixed bridges and removable partial dentures are not payable for people under age 16.
    d. A reline or the complete replacement of denture base material is payable once in any three-year period per appliance.
    e. Implant removal is payable once per lifetime per tooth or area.
    f. Implant maintenance is payable once per calendar year.
14. Orthodontic Services limitations:
    a. Orthodontic Services are payable for Eligible Persons under age 19.
    b. If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
    c. Upon written notification to Delta Dental and to the patient, a Dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
15. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a claim for those services within one year of the date of service.
16. When services in progress are interrupted and completed later by another Dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each Dentist.
17. Care terminated due to the death of an Eligible Person will be paid to the limit of Delta Dental's liability for the services completed or in progress.
18. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

    Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.
    a. Plastic, resin, porcelain fused to metal, and porcelain crowns on posterior teeth – Delta Dental will pay only the amount that it would pay for a full metal crown.
    b. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
    c. Plastic, resin, or porcelain/ceramic onlays on posterior teeth – Delta Dental will pay only the amount that it would pay for a metallic onlay.
    d. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.
    e. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.
    f. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
    g. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
    h. Stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.
19. Maximum Payment:
    a. The maximum Benefits payable in any one Benefit Year will be limited to the Maximum Payment stated in the Summary of Dental Plan Benefits.
    b. Delta Dental's payment for Orthodontic Services will be limited to the annual or lifetime Maximum Payment stated in the Summary of Dental Plan Benefits.
20. If a Deductible amount is stated in the Summary of Dental Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.
21. Processing Policies may limit Delta Dental's payment for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Participating Dentists may not charge Eligible Persons for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental Plan or, at the request of your group, any dental plan:

1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
3. Recementation of a crown, onlay, inlay, space maintainer, or bridge within six months of the seating date.
4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
5. Root planing is payable once in any two-year period.
6. Periodontal surgery is payable once in any three-year period.
7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
8. Tissue conditioning is payable twice per arch in any three-year period.

9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
11. Processing Policies may limit Delta Dental's payment for services or supplies.

VIII. Coordination of Benefits

The Coordination of Benefits ("COB") provision applies when a Person has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans does not exceed 100 percent of the total Allowable Expense.

Definitions

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, health insuring corporation ("HIC") contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56 ; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan, for purposes of this Article VIII, means the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its Benefits first before those of any other Plan without considering any other Plan's Benefits. When This Plan is secondary, it determines its Benefits after those of another Plan and may reduce the Benefits it pays so that all Plan benefits do not exceed 100 percent of the total Allowable Expense.

Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following examples are not Allowable Expenses:

1. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
2. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
3. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans.
4. Notwithstanding numbers 1,2, and 3 above, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed Panel Plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefits Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
2. Except as provided in paragraph 3 below, a Plan that does not contain a COB provision that is consistent with Ohio regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.
3. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
4. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
5. Each Plan determines its order of benefits using the first of the following rules that apply:

   Non-Dependent or Dependent. The plan that covers the Person other than as a dependent, For example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the plan that covers the person as a dependent is the Secondary Plan. However, if the Person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

   Dependent Child covered under more than one Plan. Unless there is a court decree stating otherwise, when a dependent Child is covered by more than one Plan the order of benefits is determined as follows:

   a. For a dependent Child whose parents are married or are living together, whether or not they have ever been married:
      - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

      However, if one spouse's Plan has some other coordination rule (for example, a "gender rule" which says the father's Plan is always primary), we will follow the rules of that Plan.
   b. For a dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      - If a court decree states that one of the parents is responsible for the dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
      - If a court decree states that both parents are responsible for the dependent Child's health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits;
      - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent Child, the provisions of subparagraph (a) above shall determine the order of benefits; or
      - If there is no court decree allocating responsibility for the dependent Child's health care expenses or health care coverage, the order of benefits for the Child are as follows:
        (1) The Plan covering the Custodial Parent;
        (2) The Plan covering the spouse of the Custodial Parent;
        (3) The Plan covering the non-custodial parent; and then
        (4) The Plan covering the spouse of the non-custodial parent.
   c. For a dependent Child covered under more than one Plan of individuals who are not the parents of the Child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Child.

   Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled "Non-Dependent or Dependent" can determine the order of benefits.

   COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled "Non-Dependent or Dependent" can determine the order of benefits.

   Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of This Plan

When This Plan is secondary, it may reduce its Benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, Benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. Delta Dental may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. Delta Dental need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give Delta Dental any facts it needs to apply those rules and determine Benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under This Plan. If it does, Delta Dental may pay that amount to the organization that made that payment.

That amount will then be treated as though it were a Benefit paid under This Plan. Delta Dental will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. You or your Dentist should contact Delta Dental’s Customer Service department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, (800) 524-0149, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at PO Box 9089, Farmington Hills, Michigan, 48333-9089. You may also follow the Claims Appeal Procedure below. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department’s website at http://insurance.ohio.gov.

IX. Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your claim, you or your Dentist should contact Delta Dental’s Customer Service department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, (800) 524-0149, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at PO Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your claim. This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems, or submit an explanation or additional information that might indicate your claim was improperly denied, and allow Delta Dental to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental informally to recheck its initial determination, you can request a formal review using the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination, you, or your authorized representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date that you received that Adverse Benefit Determination.

To request a formal review of your claim, send your request in writing to: **Dental Director, Delta Dental, PO Box 30416, Lansing, Michigan 48909-7916.** Please include your name and address, the Subscriber’s Member ID, the reason why you believe your claim was wrongly denied, and any other information you believe supports your claim. You also have the right to review the contract between Delta Dental and your employer or organization and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

The Dental Director or any person reviewing your claim will not be the same as, nor subordinate to, the person(s) who initially decided your claim. The reviewer will grant no deference to the prior decision about your claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your claim even if the information was not available when your claim was initially decided. If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person's subordinate consulted during the initial determination. The reviewer will make a determination within 60 days of receipt of your request. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for dental claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your claim free of charge. This notice will also contain a description of any additional materials necessary to complete your claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

If you are still not satisfied, you may contact the Ohio Department of Insurance for instructions on filing a consumer complaint by calling (614) 644-2673 or (800) 686-1526. You may also write to the Consumer Services Division of the Ohio Department of Insurance, 50 W. Town St., Third Floor, Suite 300, Columbus, Ohio, 4321543215 or visit the Department's website at http://insurance.ohio.gov.

X. Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- ♦ When your employer or organization advises Delta Dental to terminate your coverage.
- ♦ On the first day of the month for which your employer or organization has failed to pay Delta Dental.
- ♦ For fraud or misrepresentation in the submission of any claim.
- ♦ For your Children, when they no longer qualify as an Eligible Dependent.
- ♦ For any other reason stated in the contract between Delta Dental and your employer or organization.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by your employer or organization. A person whose eligibility is terminated may not continue group coverage under this Certificate, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 or comparable, non-preempted state law ("COBRA").

XI. Continuation of Coverage

If your employer or organization is required to comply with COBRA and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and your dental coverage would otherwise end, you and your Eligible Dependents may have the right to continue that coverage at your expense.

When is Plan Continuation Coverage Available?

Continuation coverage is available if your coverage or a covered Eligible Dependent's coverage would end because:

1. Your employment ends for any reason other than your gross misconduct.
2. Your hours of work are reduced so that you are no longer a full-time employee.
3. You are divorced or legally separated.
4. You die.
5. Your Child is no longer an Eligible Dependent (for example, because he or she turns 19).
6. You become enrolled in Medicare (if applicable).
7. You are called to active duty in the armed forces of the United States.

If you believe you are entitled to continuation coverage, you should contact your employer or organization to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 ("ERISA").

XII. General Conditions

<u>Assignment</u> Services and Benefits are for the personal benefit of Eligible Persons and cannot be transferred or assigned, other than to pay Participating Dentists directly.

<u>Subrogation and Right of Reimbursement</u> If Delta Dental pays Benefits under This Plan and you have the right to recover benefits or damages from another, Delta Dental is entitled to seek recovery and recoup expenses. You or your legal representative must do whatever is necessary to enable Delta Dental to exercise its rights. If you or your Eligible Dependent recover damages from another party, his or her insurer, or under his or her "Medical Payments" coverage or any "Uninsured Motorist" provisions, you must reimburse Delta Dental from that recovery. For example, your teeth are broken in a car accident and Delta Dental pays for crowns to repair them. The auto insurance company also pays for those crowns. You are obligated to reimburse Delta Dental for the amount it paid for those crowns.

<u>Obligation to Assist in Delta Dental's Reimbursement Activities</u> If you are involved in an automobile accident or require Covered Services that may entitle you to recover from a third party and Delta Dental advances payment to prevent any financial hardship to you or your family, you and your Eligible Dependents have an obligation to help Delta Dental obtain reimbursement for the amount of the payments advanced for which another source was also responsible for making payment. You and your Eligible Dependents are required to provide Delta Dental with any information about any other insurance coverage (including, but not limited to, automobile, home, and other liability insurance coverage, and coverage under another group health plan), and the identity of any other person or entity, and his or her insurers (if known), that may be obligated to provide payments or benefits for the same Covered Services that Delta Dental already paid. Eligible Persons must:

1. Cooperate fully in Delta Dental's exercise of its right to subrogation and reimbursement,
2. Not do anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co-payee of any settlement amount),

3. Sign any document that Delta Dental determines is relevant to protect Delta Dental's subrogation and reimbursement rights, and
4. Provide relevant information when requested.

The term "information" includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help Delta Dental enforce its rights. Failure by an Eligible Person to cooperate with Delta Dental may result, at the discretion of Delta Dental, in a reduction of future benefit payments available to that person under This Plan of an amount up to the aggregate amount paid by Delta Dental that was subject to Delta Dental's equitable lien, but for which Delta Dental was not reimbursed.

Obtaining and Releasing Information While you are an Eligible Person, you agree to provide Delta Dental with any information it needs to process your claims and administer your Benefits. This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship Eligible Persons are free to choose any Dentist. Each Dentist maintains the dentist-patient relationship and is solely responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility During Treatment If an Eligible Person loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under This Plan will be payable. Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility.

Late Claims Submission Delta Dental will make no payment for services or supplies if a claim for such has not been received by Delta Dental within one year following the date the services or supplies were completed.

Change of Certificate or Contract No agent has the authority to change any provisions in this Certificate or the provisions of the contract on which it is based. No changes to this Certificate or the underlying contract are valid unless Delta Dental approves them in writing.

Actions No action on a legal claim arising out of or related to this Certificate will be brought within 60 days after notice of the legal claim has been given to Delta Dental, unless prohibited by applicable state law. In addition, no action can be brought more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, if longer. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. This provision does not preclude you from seeking a judicial decision once all administrative appeals have been exhausted.

Change of Status You must notify Delta Dental, through your employer or organization, of any event that changes the status of an Eligible Dependent. Events that can affect the status of an Eligible Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

Governing Law This Certificate and the underlying group contract will be governed by and interpreted under the laws of the state of Ohio.

Right of Recovery Due to Fraud If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a claim that contains false or misrepresented information, or pays a claim that is determined to be fraudulent due to your acts or acts of your Eligible Dependents, it may recover that payment from you or your Eligible Dependents. You and your Eligible Dependents authorize Delta Dental to recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Eligible Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Legally Mandated Benefits If any applicable law requires broader coverage or more favorable treatment for you or your Eligible Dependents than is provided by this Certificate, that law shall control over the language of this Certificate.

Any person intending to deceive an insurer, who knowingly submits an application or files a claim containing a false or misleading statement, is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. We only accept anti-fraud calls at this number.

ANTI-FRAUD TOLL-FREE HOTLINE:

(800) 524-0147