DELTA DENTAL®

PPO Plus Premier® Individual Preventive Plus-Policy
Delta Dental of Iowa

MEMBER POLICY

Right to return policy

You have the right to return this Policy within 10 calendar days after the day *we* mailed this Policy to *you*. If *you* choose to return this Policy to *us* within the 10-day period, *we* will refund any premium that *you* have paid. If *you* return this Policy within the 10-day period, it will be void and *we* will have no liability under any of the terms or provisions of this Policy. There will be no coverage for any claims incurred.

Renewability

This Policy remains in effect at the option of the *policyholder* except as provided in the "When Coverage Ends" section of this Policy.

This Policy and the insurance it provides becomes effective 12:01 a.m. (*your* time) on the *Policy Effective Date* stated on the confirmation page of the welcome package. This Policy and the insurance it provides terminate at 12:00 midnight (*your* time) on the date of termination. The provisions stated above and on the following pages are part of this Policy.

Individual - Preventive Plus
Print Date: 01/01/2022
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HDS ID: Product, 10252461 (Off Exchange)
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Hello!

You have dental insurance. That's great! All of us at Delta Dental of Iowa are happy we can help you have a healthy smile and better oral health in general.

This packet includes details about your coverage. We know insurance isn't usually an exciting topic. But reading this will help you better understand your benefits and get the most out of them.

For instance, you'll learn:

- Which kinds of dental services are covered and are not covered
- What part of the costs you pay and what part we'll pay
- Why seeing an in-network dentist could save you money
- How we decide what services are covered
- When to check with us before getting a service
- Other things that will help you get the most out of your benefits

So keep reading. You'll be glad you did. And if you have any questions about your Policy or need to make a change, just give us a call at 877-423-3582, ext. 3, Monday through Friday or email us at IndividualProduct@deltadentalia.com. If you have questions about a claim you can contact us at (800) 544-0718 or email us at Claims@deltadentalia.com.

Understanding this Policy
Here are some things to keep in mind as you look over the Policy.

Let's keep it casual
Insurance is complicated enough. So instead of saying "Eligible Covered Persons" all the time, we'll say *you* and *your* to refer to you and anyone else who's covered under this Policy. And instead of saying "Delta Dental of Iowa," we'll say *we*, *us* and *our*.

Questions about what's covered
Sometimes questions arise about your Policy. When that happens, we'll help you understand the benefits and the reasons for our decisions.

Keep in mind, we interpret the terms of this Policy and make all decisions regarding coverage based on it. This includes deciding whether you meet our written eligibility requirements. If there are questions about whether a certain dental procedure is necessary and appropriate, we'll make the decision based on factual information. Our decisions are final and conclusive.

To obtain benefits under this Policy there are certain procedures you must follow. These procedures appear in different sections of this Policy, so keep reading so that you fully understand.

Sometimes laws change
In this Policy, we refer to certain laws and regulations. These laws can and do change from time to time. If you have a question about the impact of laws and regulations on your Policy, please contact us.

And finally…
This Policy is a certified Qualified Health Plan (or more accurately, a Stand-alone Dental Plan ("SADP")) in the Health Insurance Marketplace.

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Summary of benefits and payment

What part of your dental costs will you pay? This chart gives you a summary outline of the benefits provided and the payments for which you are responsible. For details, go to the **Benefits for Adults/Child(ren)** sections. One quick note — "Non-par" in these charts means Non-Participating Dentists. Those are dentists who have chosen not to participate in the Delta Dental network.

Adult Benefit Chart

You receive benefits from the categories below:	**From a type of dentist below**	**You pay the applicable deductible for the benefits? (Yes/No)**	**You pay the Coinsurance percentage below**	**The benefits used count against the Benefit Period Maximum? (Yes/No)**
Benefit Categories	**Type of Network**	**Your Deductible***	**Member Coinsurance****	**Benefit Period Maximum or Annual Maximum*****
	PPO	$50		No Limit
	Premier	$50		
	Non-par	$75		
Check-ups and teeth cleanings (Diagnostic and Preventive)	PPO	Yes	20%	Yes
	Premier	Yes	30%	Yes
	Non-par	Yes	50%	Yes
Cavity repair and tooth extractions (Routine and Restorative Services)	PPO	Yes	50%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	70%	Yes
Posterior composite(s) (Tooth-colored filling(s) on back teeth)	PPO	Yes	50%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	70%	Yes

*Deductible is per person, paid once per Benefit Period.

Member Coinsurance is the percent of costs ***you pay* each time you receive certain covered services.

Benefit Period Maximum or Annual Maximum is the maximum dollar amount ***we'll pay for all Covered Services for each Covered Person (Adult) under the Policy in a Benefit Period.

Child(ren) Benefit Chart

You receive benefits from the categories below:	From a type of dentist below	You pay the applicable Deductible for the benefits? (Yes/No)	You pay the Coinsurance percentage below	The amounts you pay count towards the MOOP? (Yes/No)
Benefit Categories	**Type of Network**	**Your Deductible***	**Member Coinsurance****	**Maximum Out of Pocket Limit (MOOP)*****
	PPO	$25		[$375/$750]
	Premier	$25		[$375/$750]
	Non-par	$225		n/a
Check-ups and teeth cleanings (Diagnostic and Preventive)	PPO	No	0%	Yes
	Premier	No	0%	Yes
	Non-par	No	50%	No
Cavity repair and tooth extractions (Routine and Restorative Services)	PPO	Yes	20%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	70%	No
Posterior composite(s) (Tooth-colored filling(s) on back teeth)	PPO	Yes	60%	Yes
	Premier	Yes	60%	Yes
	Non-par	Yes	70%	No
Root canals (Endodontic Services)	PPO	Yes	50%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	70%	No
Gum and bone disease (Periodontal Services)	PPO	Yes	50%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	70%	No
High-cost restorations (Restorations)	PPO	Yes	50%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	70%	No
Dentures and bridges (Prosthetics)	PPO	Yes	50%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	70%	No
Dental implants (Prosthetics)	PPO	Yes	60%	Yes
	Premier	Yes	60%	Yes
	Non-par	Yes	70%	No
Straighter teeth (Medically Necessary Orthodontics)	PPO	No	50%	Yes
	Premier	No	50%	Yes
	Non-par	No	50%	No

*Deductible is per person, paid once per Benefit Period.

** Member Coinsurance is the percentage of costs ***you pay*** each time you receive certain covered services.

*** The Maximum Out of Pocket Limit ("MOOP") is the maximum dollar amount ***you will pay*** for all covered services, including Deductibles and Coinsurance. The MOOP for any one Child is $375 in a Benefit Period and $750 for all Children in a Benefit Period.

Important information

Your Delta Dental PPO Plus Premier™ Policy is provided by Delta Dental of Iowa.

We've designed this Policy to encourage you and your family to get regular, preventive dental care. That helps to keep your teeth healthy. And it helps to control costs—for you and for us.

A big part of this program is our network of dentists. Our network consists of:

- PPO Panel Dentists; and
- Premier Panel Dentists

Of course, you can see just about any dentist you want. But there are usually some pretty big advantages for you—like cost savings—when you see a PPO Panel Dentist or Premier Panel Dentist. Together, these two groups of dentists make up our Delta Dental Participating Dentist network. Regardless of your dentist's physical location, if your dentist participates with Delta Dental, they are participating with Delta Dental of Iowa.

Generally, you'll save the most when you see PPO Panel Dentists.

The majority of dentists in the U.S. are either PPO Panel Dentists or Premier Panel Dentists. Some dentists, though, choose not to participate in our network. We refer to them as **Non-Participating Dentists**.

How much you pay for Covered Services depends on the benefit category of services you receive and the dentist you receive services from. See the **Summary of Benefits and Payment** charts for an outline of your payment when you see a PPO Panel Dentist, Premier Panel Dentist or a Non-Participating Dentist.

What you should know about PPO Panel Dentists

We have contracts with PPO Panel Dentists throughout the state. These contracts subject the dentist to our applicable fee schedule or Maximum Plan Allowance. See **Understanding terms and amounts you pay to share costs** section for a definition of the Maximum Plan Allowance.

When you see PPO Panel Dentists:

- They've agreed to accept Delta Dental's PPO Fee Schedule. This usually means cost savings for you for covered services.
- Your Deductible or Member Coinsurance may be less for covered services than if you see a Premier Panel Dentist or a Non-Participating Dentist.
- They've agreed to file claims for you, and we settle claims directly with them. This means less paperwork and fewer phone calls for you.
- They've agreed to handle the Pre-Treatment Estimate for you. See Pre-Treatment Plan Estimate section for more information.
- They've agreed they'll be paid the lesser of (i) their Billed Charge or (ii) our applicable fee schedule or (iii) the Maximum Plan Allowance for Covered Services. (Keep in mind, this doesn't apply in situations where we don't pay for any part of a service. For example, when you haven't met a Waiting Period or your Deductible, and/or if you've gone over your Benefit Period Maximum.) In these situations, the PPO Panel Dentist is not limited in the amount of payment they may collect from you. See Definitions of common payment terms section later in this section.

What you should know about Premier Panel Dentists

We have contracts with Premier Panel Dentists throughout the state. These contracts include payment arrangements based on Dental Dental's applicable fee schedule or on our Maximum Plan Allowance, which usually results in savings for you.

When you see Premier Panel Dentists:

- They agree to accept the Delta Dental Maximum Plan Allowance. This could mean savings for you for Covered Services.
- Your Deductible or Member Coinsurance may be *more* for Covered Services than if you saw a PPO Panel Dentist. But you'll pay less than if you saw a Non-Participating Dentist.
- They've agreed to file claims for you, and we settle claims directly with them. This means less paperwork and fewer phone calls for you.
- They've agreed to handle the Pre-Treatment Estimate for you. See the **Pre-Treatment Plan Estimate** section for more information.
- They've agreed that they'll be paid the lesser of (i) their Billed Charge or (ii) our Maximum Plan Allowance for Covered Services. (Keep in mind that this doesn't apply in situations where we don't pay for any part of a service. For example, when you haven't met the Waiting Periods or Deductibles, and/or if you've gone over your Benefit Period Maximum.) In these situations, the Premier Dentist is not limited in the amount of payment they may collect from you.

What you should know about Non-Participating Dentists

Non-Participating (non-par) dentists are those who've chosen not to join a Delta Dental network. That means there's no contract or payment arrangement in place with these dentists, so you won't get the advantages that our participating dentists offer, like lower fees.

When you see Non-Participating Dentists:

- They haven't agreed to accept their local Delta Dental Member Company's PPO payment arrangement or any other payment arrangement. They can charge whatever they want.
- You're responsible for any difference between the dentist's Billed Charge and the Delta Dental Non-Participating Dentist fee schedule.
- They're not responsible for filing your claims or settling your claims with us. That means you'll need to take care of any paperwork and phone calls about your claims.
- We settle claims with you, not the Non-Participating Dentist. However, for Iowa Non-Participating Dentists, the payment will be mailed to you, but the check may be payable to the Non-Participating Dentist. You are responsible for paying your dentist in full. This includes any Deductible, Member Coinsurance and non-approved charges you may owe.
- They don't agree to handle the Pre-Treatment Estimate for you. See **Pre-Treatment Plan Estimate** section for more information.
- Non-Participating Dentist may charge for "infection control." This includes the cost for services and supplies associated with sterilization procedures. You're responsible for these extra charges. (All dentists are legally required to follow certain infection control guidelines. But PPO Panel Dentists and Premier Panel Dentists incorporate these costs into their normal fees—so they don't charge an extra fee for infection control.)

Keeping an eye on quality and cost

Although a procedure may be listed in a given section as a Benefit, it is important to note that before you are eligible to receive benefits, we first answer the following questions. This helps us ensure you are receiving the right dental care and at the right cost. We ask:

Is the procedure Dentally Necessary?
Both of these must be true for the procedure to be Dentally Necessary:

- The diagnosis is proper and
- The treatment is necessary to preserve or restore the basic form and function of the tooth (or teeth) and the health of the gums, bone, and other tissues supporting the teeth.

Is the procedure Dentally Appropriate?
All of this must be true for the procedure to be Dentally Appropriate:

- The treatment is the most appropriate for your situation and
- The treatment meets professionally recognized standards of dental care, and complies with our clinical criteria and
- The treatment doesn't cost more than other procedures that would be equally effective for the treatment or maintenance of your teeth and their supporting structures. (If this isn't the case, you're responsible for paying the difference. This applies to any services provided).

Do policy limitations apply?
Policy limitations are amounts that are your responsibility based on your Policy with us. Here are some examples:

- Amounts for procedures that aren't dentally necessary or dentally appropriate.
- Amounts for procedures that aren't covered by this Policy.
- Amounts for procedures that have frequency or dollar limits (For example, teeth cleanings are covered twice per Benefit Period. Additional teeth cleaning may not be covered—even if your dentist says it's dentally necessary and dentally appropriate. See Benefits for a description of covered procedures and limitations associated with certain procedures.)
- Amounts for procedures that have reached policy maximums. See the **Summary of Benefits and Payment** charts at the beginning of this Policy.
- Any difference between the dentist's Billed Charge and the applicable fee schedule, or the Maximum Plan Allowance. This only applies:
    - If you receive services from a Non-Participating Dentist, or
    - To procedures that aren't Covered Services, or
    - To services from a PPO Panel Dentist or a Premier Panel Dentist that aren't paid by us to some extent, or
    - To Deductible(s) and Member Coinsurance.

Our payment policy

We send payment after the treatment is complete —not before. For example, we'll send our payment for:

- A crown when it's seated or placed.
- A fixed or removable prosthesis when it's inserted.
- Dentures when delivered.
- A root canal when it's filled.

Definitions of common payment terms

We work with insurance all the time. But you probably don't. So, let's make sure we're on the same page when we talk about your benefits and payments. These definitions will help.

Benefit Period
A Benefit Period is the same as a calendar year. It begins on the day your coverage goes into effect and starts over each January 1. We use your Benefit Period to calculate your Deductible, Benefit Period Maximum, and Maximum Out of Pocket if applicable.

Billed Charge
The Billed Charge is the amount a dentist bills for a specific dental procedure.

Covered Services
Covered Services means dental services allowed under a dental plan administered by us.

Delta Dental Member Company
A company that's an active member or affiliate member of Delta Dental Plans Association (as defined in the Delta Dental Plans Associations bylaws).

Covered Person(s)
Covered Person(s) means any individual who has enrolled, been accepted by Delta Dental of Iowa, and paid for coverage and the individual's eligible Spouse and/or eligible Child (ren).

An **Adult** Covered Person is age 21 or older as of January 1 of the Benefit Period and may be:

- You, the policyholder
- Your eligible Spouse or Domestic Partner
- An adult child who is age 21 or older as of January 1 of the Benefit Period

Spouse means your husband or wife as the result of a marriage that's legally recognized in Iowa. Your Domestic Partner may be a Covered Person — as long as you don't qualify for coverage under common law marriage and you aren't legally married to anyone else.

A Domestic Partner is a person who:

- Has shared a permanent residence with you for more than one year
- Is at least 18 years old
- Isn't a blood relative any closer than would prohibit legal marriage in Iowa

A **Child** Covered Person is under age 21 as of January 1 of the Benefit Period and may be:

- Your natural child
- A child placed with you for adoption
- A legally adopted child
- A child for whom you have legal guardianship
- A stepchild
- A foster child

A soon-to-be or previously adopted child is eligible for coverage as of the date of placement for adoption, the date of the issuance of a final decree or upon an interlocutory adoption decree becoming a final adoption decree, whichever occurs first.

Maximum Plan Allowance
Maximum Plan Allowance is the amount we establish as the maximum allowable fee for certain Covered Services provided by Premier Panel Dentists. For services billed by Premier Panel Dentists outside of Iowa, the Maximum Plan Allowance is based on information from that state's Delta Dental Member Company.

We establish the Maximum Plan Allowance for dental services contained in the "Current Dental Terminology," book published by the American Dental Association. Several factors are taken into consideration, including but not limited to:

- Contracts with dentists
- The simplicity or complexity of the procedure
- The Billed Charge for the same procedure by dentists in the same geographic area, with similar training and skills
- Leading economic indicators, like the Consumer Price Index

Policy Effective Date

The Policy Effective Date is the first day the dental coverage was in effect for you with Delta Dental.

PPO Schedule

The PPO Schedule is a reduced fee schedule used to pay PPO Panel Dentists for certain Covered Services. This is what helps you save money on your dental care.

Understanding the terms and amounts you pay to share costs.

Deductible
Deductible is the dollar amount you pay for Covered Services for each Covered Person in a Benefit Period before benefits are available under this Policy (or, in other words, before we start paying under the Policy). This amount is shown on the **Summary of Benefits and Payment** charts at the beginning of this Policy.

Please note: The Deductible is paid once, per Covered Person, each Benefit Period.

Member Coinsurance
Coinsurance is the sharing of dental expenses between Delta Dental and you. The Member Coinsurance is the percentage of the dental expense you pay each time you receive certain Covered Services. The Member Coinsurance amounts are shown on the **Summary of Benefits and Payment** charts at the beginning of this Policy.

Your coinsurance starts once you fulfill your deductible (if one applies). It's calculated based on the applicable fee schedule. In general, your coinsurance percentage depends on the benefit category of the service you receive and the participation status of your dentist.

Benefit Period Maximum or Annual Maximum
The Benefit Period Maximum or Annual Maximum is the maximum amount we may pay for each Covered Person for all Covered Services in a Benefit Period. No further benefits are payable once the Benefit Period Maximum or Annual Maximum has been met. This amount is shown on the **Summary of Benefits and Payment** charts at the beginning of this Policy, if applicable.

Maximum Out of Pocket Limit
The Maximum Out of Pocket Limit ("MOOP") is the maximum amount you pay per Benefit Period for certain Covered Services provided by PPO Panel Dentist or Premier Panel Dentist. This includes payments for your Deductible and Member Coinsurance. This amount is shown on the **Summary of Benefits and Payment** charts at the beginning of this Policy, if applicable. Keep in mind, the MOOP only applies to Child(ren) benefits.

Once you've reached your MOOP, we pay 100% of Covered Services (benefit limitations still apply) provided by PPO Panel or Premier Panel Dentists through the end of the Benefit Period. Note: There's no Maximum Out of Pocket Limit for Covered Services provided by Non-Participating Dentists. So, you should expect to pay more when you see dentists who are not in our network.

Other payment responsibilities
In addition to the above, you will be responsible for paying dental care charges when Delta Dental does not make any payment because you have not exhausted your Waiting Period, paid your Deductible or Member Coinsurance, or have exceeded your Benefit Period Maximum, or frequency limitations. This is the case even when a PPO Panel Dentist or Premier Panel Dentist provided the services.

Help when you have questions
If you have questions after reading this Policy, please call using the contact information on the back cover of this Policy.

Benefits for Adults

Check-ups and teeth cleaning (Diagnostic and Preventive Services)		
Benefit	**Description**	**Limit (if any)**
Dental Cleaning (Prophylaxis)	Removing plaque, tartar (calculus) and stain from teeth and implants.	This procedure is a benefit twice per Benefit Period.
Oral Evaluations	A dental exam that includes checking for cavities, gum disease and any other concerns in the mouth, face, and neck that are related to the oral cavity.	This procedure is a benefit twice per Benefit Period. This includes all dental exams including preventative, comprehensive, consultations and problem focused exams.
Bitewing X-Rays	Shows the crowns of the upper and lower teeth at the same time; held in place by a tab between the teeth.	This procedure is a benefit once every 24 consecutive months if there is no history of restorations in the previous 24 months; if there is a history of restorations in the previous 24 months, bitewing x-rays are a benefit once every 12 consecutive months.
Cone Beam CT X-Rays	Produce a three-dimensional (3-D) scan of teeth, soft tissues, nerve pathways and bone in a single scan.	This procedure is a benefit once per Benefit Period.
Full-Mouth X-Rays	Combination of individual x-rays taken by a dentist on the same service date.	This procedure is a benefit once every five consecutive years. Note: A panoramic x-ray is a benefit if full-mouth x-rays haven't been done within five (5) years of the panoramic x-ray.
Occlusal x-rays	Capture all upper and lower teeth in one image; the film rests on the biting surface of the teeth.	This procedure is a benefit once every 12 consecutive months.
Periapical x-rays	A radiographic image of a tooth (or some teeth) that shows the crown and root portions.	

Cavity repair (Routine and Restorative Services)		
Benefit	**Description**	**Limit (if any)**
Emergency Treatment (Palliative Treatment)	Treatment used in an emergency situation to relieve pain, swelling, bleeding or infection caused by a dental problem.	
Restoration of Decayed or Fractured Teeth	Restorations such as silver (amalgam) fillings and tooth-colored (composite) fillings. This also includes pre-formed or	Restorations are a benefit once every 24 months per tooth.

	stainless-steel restorations.	
Limited Occlusal Adjustment	Reshaping the biting surfaces of one or more teeth.	This procedure is a benefit twice every 12 consecutive months.

Services Not Covered (Policy Exclusions) – Adult

This Policy does not provide benefits for the treatment, service or supplies in this section. Just because a treatment, service, or supplies aren't specifically listed here doesn't mean it's covered. If you're not sure if something is covered, call us at the number provided on the back cover of this Policy. We're happy to help.

Treatment, Service or Supplies:	What's NOT covered (Excluded) - You are not covered for:
Anesthesia or analgesia	Adults – You are not covered for general anesthesia, intravenous sedation, local anesthesia, non-intravenous conscious sedation or nitrous oxide (relative analgesia).
Broken appointments	Fees charged by your dental office because of broken appointments.
Complete occlusal adjustment	Services or supplies used to revise or alter the functional relationships between upper and lower teeth.
Complications of a non-covered procedure	Costs related to dental problems that result from a non-covered procedure.
Congenital deformities	Services or supplies to fix congenital deformities, such as cleft palate.
Controlled Release Device	You are not covered for services or supplies used for the controlled release of therapeutic agents into diseased crevices around your teeth.
Cosmetic in nature	Services or supplies that are mainly to improve the appearance of your teeth rather than restoring or improving dental form and function of natural teeth.
Desensitizing medicament or resin	The application of desensitizing medicament or resin for cervical and/or root surface sensitivity either on a per tooth or per visit basis.
Drugs	Prescription or non-prescription drugs or medications.
Effective date	Services or supplies received before the Policy Effective Date of coverage under this Policy.
Experimental or Investigative	Services or supplies that are considered experimental, investigative or have a poor prognosis. We will use Peer-reviewed outcomes data from clinical trials, Food and Drug Administration regulatory status, and established governmental and professional guidelines to make this determination.
Extraoral x-rays	Extraoral x-rays if you are an Adult.
Government programs	Services or supplies when you're entitled to benefits from government programs (except Medicaid and CHIP).
Gum and Bone Diseases (Periodontal Services)	You are not covered for services or supplies for periodontal services including conservative, complex, or maintenance periodontal procedures.
High Cost Restorations (Cast Restorations)	You are not covered for services or supplies for cast restoration services, including crowns, inlays, and onlays.
Implants	You are not covered for any dental implants which are surgically placed in the jawbone. You are also not covered for the

	attachment of any device to a surgically placed implant in the jawbone.
Incomplete services	Dental services that haven't been completed.
Indirect pulp caps	Indirect pulp caps are not covered.
Infection control	Separate charges for "infection control." This includes the costs for services and supplies for sterilization procedures and personal protective equipment. Delta Dental Dentists include these costs into their normal fees.
Lost or stolen appliances	Services or supplies to replace lost or stolen dental appliances.
Medical services or supplies	Services or supplies that are medical in nature, including, but not limited to: Dental services performed in a hospital Treatment of fractures and dislocations Treatment of cysts and malignancies Accidental injuries
Military service	Services or supplies needed to treat an illness or injury received while you're on active status in the military services. However, if you ask in writing, you may get a refund of premiums you paid while on active military status.
Oral Surgery	You are not covered for oral surgery including removal of teeth, and other surgical services to the teeth.
Payment responsibility	Services or supplies when: Someone else has the legal obligation to pay for your care; and, When you wouldn't be charged if you did not have this Policy.
Periodontal appliances	You are not covered for services or supplies for periodontal appliances (bite guards) to reduce bite (occlusal) trauma due to tooth grinding or jaw clenching.
Periodontal splinting	Services or supplies used mainly for reducing tooth mobility, including crown-type restorations.
Plaque-control programs, oral hygiene instructions and dietary instructions	Services or supplies for plaque control, oral hygiene and/or dietary instructions are not covered.
Policy termination	Any treatment received after the coverage termination date of this Policy.
Prosthetics (Bridges, Dentures, and Dental Implants)	You are not covered for services or supplies for prosthetics including bridges, dentures, and dental implants.
Provisional crowns, bridges or dentures	Services or supplies for provisional crowns, bridges or dentures are not covered.
Repair, replacement or duplication of orthodontic appliances	Services or supplies needed to fix, replace or duplicate any orthodontic appliance are not covered.
Root Canals (Endodontics)	You are not covered for endodontic services including apicoectomy/periradicular surgery, direct or indirect pulp cap, pulpotomy, retrograde fillings, or root canal therapy.
Sales Tax and Fees	We do not pay sales tax or fees billed by dentists for dental services.
Sealant/Preventive Resin Applications	You are not covered for services or supplies for sealant/preventive resin applications.

Services not paid to some extent by us	Services that would otherwise qualify as a Covered Service, but Delta Dental does not make a payment to some extent. This may include services not paid because of your need to satisfy applicable Waiting Periods, Deductibles, copayments, Member Coinsurance, Benefit Period Maximums, and/or frequency limitations.
Services not provided in a dental office setting	Services not provided in a dental office setting.
Space maintainers & removal	Adults are not covered for space maintainers or the removal of fixed space maintainers.
Specialized services	Specialized, personalized, elective materials and techniques or technology that aren't reasonably needed for the diagnosis or treatment of dental disease or dysfunction. Specialized services are enhancements to other services and are considered optional.
Straighter teeth - Corrective orthodontics	Corrective Orthodontic services or other procedures directly associated with orthodontics that move teeth to correct an abnormal dental relationship between and among teeth are not covered.
Straighter teeth - Medically Necessary Orthodontics	Adults are not covered for Medically Necessary Orthodontics.
Temporary or interim procedures	Temporary or interim procedures are not covered.
Temporomandibular joint dysfunction (TMD)	Costs for diagnostic x-rays, appliances, restorations or surgery for TMD or myofunctional therapy are not covered.
Tooth Extractions	You are not covered for tooth extractions.
Treatment by a non-licensed dentist or non-licensed physician	Services or treatment performed by anyone but a licensed dentist, licensed physician, or their employees. Covered Services provided in states where other types of dental providers can practice independently are allowed.
Treatment in Progress	You may not be covered for services or supplies related to treatment which began prior to the effective date of this Policy.
Unerupted teeth	Prophylactic removal of unerupted teeth (asymptomatic and nonpathological). Meaning, the removal of any unerupted tooth that aren't visible or isn't causing harm is not covered.
Workers' compensation	Services or supplies that are or could have been paid under a Worker's Compensation laws, including those applied toward any Deductible under your employer's Worker's Compensation coverage.

Benefits for Children

Check-ups and Teeth Cleaning (Diagnostic and Preventive Services)		
Benefit	**Description**	**Limit (if any)**
Dental cleaning (Prophylaxis)	Removing plaque, tartar (calculus), and stain from teeth.	The procedure is a benefit only twice per Benefit Period.
Diagnostic cast	A replica of the teeth and tissues made from an impression; it's also called a study model.	
Emergency Treatment (Palliative treatment)	Treatment used in emergency situations to relieve pain, swelling, bleeding, or infection caused by a dental problem.	
Oral evaluations	A dental exam that includes checking for cavities, gum disease and any other concerns in the mouth, face, and neck that are related to the oral cavity.	This procedure is a benefit twice per Benefit Period. Oral evaluations include all dental exams, including preventative, comprehensive, consultations and problem focused exams.
Topical fluoride applications	Professional administered procedure in which the dental surfaces are coated with a fluoride solution or gel to help prevent decay.	The procedure is a benefit only twice per Benefit Period.
Bitewing x-rays	An x-ray that shows the crowns of the upper and lower teeth at the same time and is held in place by a tab between the teeth.	The procedure is a benefit only twice per Benefit Period.
Cone Beam CT x-rays	Produce a three-dimensional (3-D) scan of teeth, soft tissues, nerve pathways and bone in a single scan.	This procedure is a benefit once per Benefit Period.
Full-mouth x-rays	Includes a combination of individual x-rays (such as periapical, bitewing, or occlusal) taken by a dentist on the same service date. A panoramic x-ray is a benefit if full-mouth x-rays have not been taken within (5) five years of the panoramic x-ray.	This procedure is a benefit only once every (5) five years.
Occlusal x-rays	Occlusal x-rays capture the floor of the mouth to show the bite of the upper or lower jaw.	This procedure is a benefit only once every 12 months.
Extraoral x-rays	Extraoral x-rays films are outside of the mouth. They show the teeth but are focused on the jaw and skull.	This procedure is a benefit only once every 12 months.
Periapical x-rays	A radiographic image of a tooth (or some teeth) that shows the crown and root portions.	
Periodontal maintenance therapy	A dental cleaning for people with a history of periodontal (gum) disease and treatment of that gum disease.	To qualify as covered periodontal maintenance services, the services must follow non-surgical or surgical periodontal therapy.

		When it does, this benefit is available: Up to (4) four times in the first Benefit Period following the initial periodontal therapy; and, Up to (4) four times in the next Benefit Period; and, Twice per Benefit Period after that. *Note: This procedure takes the place of the dental cleaning benefit (prophylaxis) described under Check-ups and Teeth Cleaning of this section.*
Sealant/preventive resin applications	A thin plastic coating on the cavity prone surfaces of molar teeth.	These procedures are a benefit once per permanent first and second molars every 24 months. This is not a benefit for primary teeth, wisdom teeth or teeth that have already been treated with a restoration.
Space maintainers for missing back teeth	Passive appliances designed to prevent tooth movement.	

Cavity Repair and Tooth Extractions (Routine and Restorative Services)		
Benefit	**Description**	**Limit (if any)**
Non-Surgical Periodontal Treatment (Root Planing and Scaling)	Deep cleaning procedure to remove dental plaque and calculus for those with gum disease which normally includes loss of the supporting bone structure.	These procedures are a benefit only once every 24 months for each quadrant of the mouth. Note: a quadrant is one of the four equal sections of the mouth into which the jaws can be divided; it includes four or more teeth or bounded teeth spaces.
Consultations	A diagnostic service provided by the dentist where the dentist and patient discuss the patient's dental needs and proposed treatment.	Consultations are benefited as oral evaluations as described under Check-Ups and Teeth Cleaning and count towards the two per benefit period limitation.
Denture adjustments	Adjustments made to the dentures to ensure proper fit or restore function, comfort or to fit.	This procedure is limited to two per denture per Benefit Period—after (6) six months have elapsed since initial placement.
Denture rebase/relining	The procedures used to resurface or replace the entire tissue side of the denture with a new base material for a more accurate or snug fit.	This procedure is a benefit only if performed (6) six months or more after the initial placement of the denture; and then once every (3) three years after.
General anesthesia/sedation	A combination of medications used to put you in a sleep-like state before and during surgery.	This procedure is a benefit only when provided with covered oral surgery and billed by the operating dentist.
Pulpotomy	Removing the coronal portion of the pulp as part of root canal therapy; when done on a baby (primary) tooth, this is the only procedure required for root canal therapy.	
Restoration of decayed or fractured teeth	Restorations such as silver (amalgam) fillings and tooth-colored (composite) fillings. This also includes pre-formed or stainless-steel restorations.	This procedure is a benefit only once per tooth every (5) five years. Stainless steel crowns are a benefit for Covered Persons who are under age 15 as of January 1 of the Benefit Period.
Routine oral surgery	Includes removal of teeth and other surgical services to the teeth or immediate surrounding hard and soft tissues; surgery must be due to disease, pathology or dysfunction of dental origin.	
Therapeutic drug injection	Includes a single administration of antibiotics, steroids, anti-inflammatory drugs or other therapeutic medications.	
Tissue conditioning	Improves the health of gum tissues under a denture.	This procedure is limited to two per denture every 36 months.

Root Canals (Endodontic Services)		
Benefit	**Description**	**Limit (if any)**
Apicoectomy/periradicular surgery	Surgery to repair a damaged root as part of root canal therapy or to correct a previous root canal.	
Direct pulp cap	Covering exposed pulp with a dressing or cement to protect it and help it heal and repair.	
Retrograde fillings	Sealing the root canal by preparing and filling it from the root end of the tooth.	
Root canal therapy	Treating an infected or injured pulp to retain tooth function; usually involves removing the pulp and replacing it with an inert filling material.	This procedure is limited to once per tooth per lifetime.

Gum and Bone Diseases (Periodontal Services) Note: Some of these procedures should be reviewed by us before they're performed. To learn more, see the Pre-Treatment Plan Estimate section.		
Benefit	**Description**	**Limit (if any)**
Alveoloplasty	Surgery for recontouring supporting bone—usually in preparation of a denture.	
Athletic Mouth Guard	An athletic mouth guard is a resilient intraoral device worn during participation in contact sports to reduce the potential for injury to the teeth and associated tissue.	An athletic mouth guard is a benefit for all eligible Covered Persons under age 19 once every 24 consecutive months.
Full mouth debridement	Preliminary removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation.	This procedure is a benefit only once in a lifetime after 36 months have elapsed since last dental cleaning (prophylaxis).
Guided tissue regeneration	Services and supplies for regeneration of lost periodontal structures.	
Surgical periodontal procedures	Various surgical interventions designed to repair and regenerate gum and bone tissues that support the teeth.	This procedure is a benefit once every 36 months for each tooth or quadrant of the mouth for natural teeth only. Note: a quadrant is one of the four equal sections of the mouth into which the jaws can be divided; it includes four or more teeth or bounded (contiguous) teeth spaces in a row.

Periodontal appliance	Removable dental appliance designed to minimize the effects of teeth grinding (bruxism) and tongue thrust.	This procedure is a benefit only once per Benefit Period for Covered Person who are 13 to 20 years of age as of January 1 of the Benefit Period.

High-cost Restorations (Restorations)

Note: Some of these procedures should be reviewed by us before they're performed. To learn more, see the Pre-Treatment Plan section.

Benefit	Description	Limit (if any)
Restorations for complicated tooth decay or fracture	Restoring a tooth with a different type of filling when the tooth cannot be restored with a silver (amalgam) or tooth-colored (composite) filling; includes local anesthesia.	This procedure is a benefit once every (5) five years, beginning from the date the cast restoration is cemented in place.
Crowns	Restoring form and function by covering and replacing the visible part of the tooth with a precious metal, porcelain- fused-to-metal or a porcelain crown;	The procedure is a benefit once every (5) five years, beginning from the date the cast restoration is cemented in place. Crowns are a benefit only if the tooth can't be restored with a routine filling Crowns placed mainly for periodontal splinting, cosmetics, altering vertical dimension, restoring your bite (occlusion) or restoring a tooth due to attrition, abrasion, erosion and abfraction are not a benefit.
Inlays	An intra-coronal dental restoration made outside the oral cavity and does not restore any cusp tips.	This procedure is a benefit once every (5) five years, beginning from the date the inlay is inserted or cemented in place. Benefit is limited to the amount paid for a silver (amalgam) filling.
Onlays	A restoration made outside the oral cavity that covers one or more cusp tips, but not the whole external surface.	This procedure is a benefit once every (5) five years, beginning from the date the onlay is inserted or cemented in place.
Posts and cores	Preparing a tooth for a crown after a root canal to strengthen the tooth.	This procedure is a benefit once every (5) five years, beginning from the date the restoration is completed.
Recementation of restorations	Recementation of an inlay, onlay or crown that has become loose.	This procedure is a benefit once every 12 months—after (6) six months have elapsed since initial placement.

Dentures and Bridges (Prosthetics)

Note: Procedures in this category should be reviewed by us before they're performed. To learn more, see the Pre-Treatment Plan Estimate section.

Benefit	Description	Limit (if any)
Bridges	Replacing missing permanent teeth with a dental prosthesis that is cemented in place and can only be removed by a dentist; bridge repairs are also covered.	This procedure is a benefit once every (5) five years.
Dentures (complete and partial)	Replacing missing permanent teeth with a removable dental prosthesis.	This procedure is a benefit once every (5) five years.

Dental Implants (Prosthetics)

Note: Procedures in this category should be reviewed by us before they're performed. To learn more, see the Pre-Treatment Estimate section.

Benefit	Description	Limit (if any)
Dental implants	Implants that are surgically placed in the jawbone, including attachment of devices to a surgically placed implant in the jaw	This procedure is a benefit once every (5) five years.

Straighter teeth (Medically Necessary Orthodontics)

Note: Medically Necessary Orthodontics requires our review and approval before treatment begins. See the Pre-Treatment Estimate section.

Benefit	Description	Limit (if any)
Medically Necessary Orthodontic Services *See additional notes below.	Orthodontic procedures benefited because of needed orthognathic surgery, certain designated syndromes or genetic disorders such as cleft palate.	These procedures are only for Covered Persons under age 21 as of the Benefit Period.

***Additional notes for Medically Necessary Orthodontics:**

- When an orthodontic treatment plan is established, we'll calculate an initial payment when the banding takes place. The rest of the allowed fee will be divided into payments over the rest of treatment (assuming coverage is still in place).
- If treatment is stopped before it's done, we'll only pay for the services and supplies received. No benefits are available for charges made after treatment stops or after coverage ends. Our payment extends only to the months of treatment received while covered under this Policy. We'll determine the months eligible for coverage.

Services Not Covered - Child (Policy Exclusions)

This Policy does not provide benefits for the treatment, service or supplies in this section. Just because a treatment, service, or supplies aren't specifically listed here doesn't mean it's covered. If you're not sure if something is covered, call us at the number provided on the back cover of this Policy. We're happy to help.

Treatment, Service or Supplies:	What's NOT covered (Excluded) - You are not covered for:
Anesthesia or analgesia	Child(ren) - non-intravenous conscious sedation.
Broken appointments	Fees charged by your dental office because of broken appointments.
Complete occlusal adjustment	Services or supplies used to revise or alter the functional relationships between upper and lower teeth.
Complications of a non-covered procedure	Costs related to dental problems that result from a non-covered procedure.
Congenital deformities	Services or supplies to fix congenital deformities, unless you qualify for Medically Necessary Orthodontics.
Cosmetic in nature	Services or supplies that are mainly to improve the appearance of your teeth rather than restoring or improving dental form and function of natural teeth.
Desensitizing medicament or resin	The application of desensitizing medicament or resin for cervical and/or root surface sensitivity either on a per tooth or per visit basis.
Drugs	Prescription or non-prescription drugs or medications.
Effective date	Services or supplies received before the Policy Effective Date of coverage under this Policy.
Experimental or Investigative	Services or supplies that are considered experimental, investigative or have a poor prognosis. We will use Peer-reviewed outcomes data from clinical trials, Food and Drug Administration regulatory status, and established governmental and professional guidelines to make this determination.
Government programs	Services or supplies when you're entitled to benefits from government programs (except Medicaid and CHIP).
Incomplete services	Dental services that haven't been completed.
Indirect pulp caps	Indirect pulp caps are not covered.
Infection control	Separate charges for "infection control." This includes the costs for services and supplies for sterilization procedures and personal protective equipment. Delta Dental Dentists include these costs into their normal fees.
Limited occlusal adjustment	Limited occlusal adjustments are not covered for Child(ren).
Lost or stolen appliances	Services or supplies to replace lost or stolen dental appliances.
Medical services or supplies	Services or supplies that are medical in nature, including, but not limited to: Dental services performed in a hospital Treatment of fractures and dislocations Treatment of cysts and malignancies Accidental injuries
Military service	Services or supplies needed to treat an illness or injury received while you're on active status in the military services. However, if

	you ask in writing, you may get a refund of premiums you paid while on active military status.
Payment responsibility	Services or supplies when: Someone else has the legal obligation to pay for your care; and, When you wouldn't be charged if you did not have this Policy.
Periodontal appliances	Child(ren) under age 13 or over age 20 are not covered for services or supplies for periodontal appliances (bite guards) to reduce bite (occlusal) trauma due to tooth grinding or jaw clenching.
Periodontal splinting	Services or supplies used mainly for reducing tooth mobility, including crown-type restorations.
Plaque-control programs, oral hygiene instructions and dietary instructions	Services or supplies for plaque control, oral hygiene and/or dietary instructions are not covered.
Policy termination	Any treatment received after the coverage termination date of this Policy.
Provisional crowns, bridges or dentures	Services or supplies for provisional crowns, bridges or dentures are not covered.
Repair, replacement or duplication of orthodontic appliances	Services or supplies needed to fix, replace or duplicate any orthodontic appliance are not covered.
Sales tax and fees	We do not pay sales tax or fees billed by dentists for dental services.
Services not paid to some extent by us	Services that would otherwise qualify as a Covered Service, but Delta Dental does not make a payment to some extent. This may include services not paid because of your need to satisfy applicable Waiting Periods, Deductibles, copayments, Member Coinsurance, Benefit Period Maximums, and/or frequency limitations.
Services not provided in a dental office setting	Services not provided in a dental office setting.
Specialized services	Specialized, personalized, elective materials and techniques or technology that aren't reasonably needed for the diagnosis or treatment of dental disease or dysfunction. Specialized services are enhancements to other services and are considered optional.
Straighter teeth - Corrective orthodontics	Corrective Orthodontic services or other procedures directly associated with orthodontics that move teeth to correct an abnormal dental relationship between and among teeth are not covered.
Straighter teeth - Medically Necessary Orthodontics	Adults are not covered for Medically Necessary Orthodontics.
Temporary or interim procedures	Temporary or interim procedures are not covered.
Temporomandibular joint dysfunction (TMD)	Costs for diagnostic x-rays, appliances, restorations or surgery for TMD or myofunctional therapy are not covered.
Treatment by a non-licensed dentist or non-licensed physician	Services or treatment performed by anyone but a licensed dentist, licensed physician, or their employees. Covered Services provided in states where other types of dental providers can practice independently are allowed.
Treatment in Progress	You may not be covered for services or supplies related to

	treatment which began prior to the effective date of this Policy.
Unerupted teeth	Prophylactic removal of unerupted teeth (asymptomatic and nonpathological). Meaning, the removal of any unerupted tooth that aren't visible or isn't causing harm is not covered.
Workers' compensation	Services or supplies that are or could have been paid under a Worker's Compensation laws, including those applied toward any Deductible under your employer's Worker's Compensation coverage.

Pre-Treatment Plan Estimate Process

When you need any kind of dental care, it's a good idea to make sure you, your dentist and your insurance company are on the same page. That's what the Pre-Treatment Plan Estimate does for you. The purpose of Pre-Treatment Plan Estimate is to help control the cost of your benefits — not to keep you from receiving dentally necessary and dentally appropriate treatment. Our benefit review is based on the treatment plan submitted by your dentist. Think of it as a system of checks and balances for your dental coverage. The Pre-Treatment Plan Estimate helps:

- Determine whether services are dentally necessary and dentally appropriate;
- Confirm the benefits of your Policy; and
- You understand your payment and ours, if covered.

What you should do

For certain dental care, you should notify us before treatment starts. For others, you must notify us and get our approval first.

You should notify us before you get services for the following benefit categories:

- Periodontal surgery
- High-cost restorations (including crowns, onlays and bridges)
- Dental implants
- Any treatment that will cost more than $300

You ***must notify*** **us** ***and get our approval before*** you get services for:

- Straighter teeth—Medically Necessary Orthodontics

What's a treatment plan?

Your dentist creates the treatment plan. It describes the treatment he or she recommends for you. It also helps us determine if the procedure is a benefit under your Policy and if it is dentally necessary and dentally appropriate.

Who sends the treatment plan to us?

As long as your dentist is a Delta Dental Participating Dentist, he or she will send the treatment plan to us. (That's another benefit of working with an in-network dentist!)

But, if your dentist is a Non-Participating Dentist, you'll need to send the treatment plan to us. A complete treatment plan includes:

- The plan of treatment, and
- X-rays (please send x-rays within 15 business days of receipt of the proposed treatment plan)

Where to send a treatment plan

If your dentist is a Non-Participating Dentist, you'll need to send the proposed treatment plan, x-rays and supporting information to:
Delta Dental of Iowa
P.O. Box 9000
Johnston, IA 50131-9000

Our review of the treatment plan

Once we get your treatment plan and related information, we'll review everything. Then we'll let you and your dentist know of our decision within 15 business days of receiving the information.

We'll either:

- Accept the treatment plan.
- Recommend an alternative benefit. If we ask you to receive a second opinion from a dentist of our choice we'll pay for the exam.
- Deny the treatment plan because:
    - The procedure isn't a benefit of your Policy;
    - You didn't get a second opinion after we asked you to; or
    - The procedure isn't dentally necessary and dentally appropriate.

What you can do if the treatment plan is denied

If we deny a treatment plan, you can ask us to reconsider. To do that, resubmit the plan with more information and ask us—in writing—to reconsider. If needed, we may have you get an exam from an independent dentist of our choice – we'll pay for the exam.

Keep in mind, even if we approve a treatment plan, we're not liable for the actual treatment you get from your dentist.

Filing claims

Once you get dental care, we need to receive a claim. The claim lets us know what services you got, as well as when and from whom.

If your dentist is a Delta Dental Participating Dentist, he or she will file the claim for you. (Another advantage of seeing in-network dentists.)

If you see a Non-Participating Dentist, though, you may need to file the claim yourself.

When to file a claim

You should only file a claim if your dentist hasn't filed one for you — and only *after* the procedure is finished.

Make sure the claim is filed promptly after the procedure is done. We may not pay a claim submitted more than 365 days after the services were provided.

If you need a claim form or have questions, please call us at 800-544-0718 or visit www.deltadentalia.com.

If you need to file your own claim, send it to:

Delta Dental of Iowa
P.O. Box 9000
Johnston, IA 50131-9000

Filing claims when you have more than one policy or other coverage.

Coordination of Benefits

You may have other dental coverage that provides the same or similar benefits as this Policy. If so, we'll work with your other insurance company to coordinate benefits. The benefits payable under both policies will not be more than 100 percent of either insurance carrier's payment arrangement amount.

When you get dental care, you need to let us know that you have other coverage. Other coverage includes:

- Group insurance (like employer-sponsored)
- Other group benefit plans (such as HMOs, PPOs and self-insured programs)
- Individual and Family dental insurance
- Medicare or other governmental benefits
- Medical benefits coverage under your auto insurance

What you should do

To help us coordinate your benefits, you should:

- Tell your dentist about your other coverage when you get services. Your dentist will pass the information on to us when the claim is filed.
- Indicate that you have other coverage when you fill out a claim form. We'll let you know if we need any additional information.
- Let us know if you lose your other coverage or it changes.

You must cooperate with us and provide requested information about your other dental coverage. If you don't, your claims will be denied.

What we'll do

We'll coordinate the benefit payments between your policies. To do this, we need to determine the order in which each policy will pay. In other words, which policy pays first, and which pays second and so on. Below are the guidelines that help us determine the payment order when you have more than one policy.

If…	Then…
Both coverages are through a group sponsor (like an employer), but one coverage has coordination of benefits and one doesn't.	The coverage without coordination of benefits pays first.
Coverage is through an auto policy, and it doesn't have a coordination of benefits provision.	The dental benefits of your auto coverage will pay before this Policy.
Coverage held as an employee or policyholder (i.e. Individual & Family policy).	It pays before the coverage you have as a Spouse or Child.
Coverage is held as an active employee.	It pays before coverage you hold as a retiree or under which you're not actively employed.
None of the above guidelines apply.	The coverage with the earliest continuous effective date pays first.

If none of the guidelines or situations above apply, we'll rely on the coordination of benefits (COB) rules provided in the Iowa Administrative Code to determine the order of payment between the polices and our payment to you or your dentist.

How we coordinate benefits for Children

Here are the guidelines we follow to coordinate benefits for your Children when they are covered by more than one dental policy.

If the Child is…	Then…
Covered by both parents who aren't separated or divorced.	The coverage of the parent whose birthday occurs first in a calendar year pays first. If the other carrier doesn't use this guideline, then the other policy will pay first.
Covered by both parents who are separated or divorced but neither parent has primary physical custody.	The coverage of the parent whose birthday occurs first in a calendar year pays first. If the other carrier doesn't use this guideline, then the other policy will pay first.
Covered by separated or divorced parents and a court decree says which parent has financial or dental insurance responsibility.	That parent's policy pays first.
Covered by separated or divorced parents and a court decree does *not* say which parent has financial or dental insurance responsibility.	The coverage of the parent with custody pays first. The payment order for this Child is: • Custodial parent • Spouse of custodial parent • Other parent • Spouse of other parent
None of the guidelines above apply.	The parent's coverage with the earliest continuous effective date pays first.

If none of the guidelines or situations above apply, we'll rely on the coordination of benefits (COB) rules provided in the Iowa Administrative Code to determine the order of payment between the polices and our payment to you or your dentist.

Appealing our claims decision

If we don't pay all or part of your claim and you think we should, you or your personal representative have the right to ask for an appeal. An appeal is a full and fair review of a claim that we didn't pay in full or in part (adverse benefit determination), without considering our initial decision. To request an appeal, submit a written request within 180 days of receiving the notice letter or explanation of benefits for the claim from us. The written request for an appeal must include:

- The reason why you disagree with our claim decision;
- Documents, records and any other information related to the claim; and,
- Your name, the patient's name and address and identification number on all documents

Our reply

Generally, within 30 days of receiving your request, we'll send you our decision in writing. We'll also tell you about any action we have taken. During this time, you may send us additional documentation to support the claim.

Sometimes we may need 60 days. If that happens, we'll let you know in writing. After that time, we'll make the final decision on the claim based on the information we have in our file.

Reviewing records

When you ask us, we'll give you access to and copies of all documents, records, and other information related to your claims for benefits. There's no cost for this.

To schedule an appointment, just call us in advance at 800-544-0718 or mail your request to:
Delta Dental of Iowa
P.O. Box 9010
Johnston, IA 50131-9010

You can review these records at our office Monday through Friday, from 8:00 a.m. to 4:30 p.m. Central Standard Time. Your records are also available online via our secure member website. To access your records online go to www.deltadentalia.com and set up an account.

Your Policy

Our responsibilities to you, as well as the conditions of your coverage with us, are defined in the documents that make up your contract. Your contract includes any application you submitted to us, this Policy, and any riders or amendments.

All of the statements made by you in any of these materials will be treated by us as representations to us, upon which we may rely. We will not use the statements to deny any claim unless we have furnished you with a copy of the statement.

Annual open enrollment period

For persons enrolling through the Health Insurance Marketplace, the annual open enrollment period is typically from November 1st to December 15th of each year. Benefits are effective on January 1st to December 31st of every year.

Eligibility enrollment requirements

To be eligible for this Policy:

- You must be a permanent Iowa resident.
- You must remain on one Delta Dental of Iowa PPO Individual and Family dental plan for 12 consecutive months before switching to another plan.
- If you drop (terminate) coverage, you will not be eligible to re-enroll in this or any other Delta Dental of Iowa PPO Individual and Family plan for 24 consecutive months, unless you've had continuous coverage with similar qualifying benefits. This rule does not apply if coverage is being purchased through a Healthcare.gov Marketplace plan during Open Enrollment or a qualifying event.
- You cannot be covered by more than one Delta Dental of Iowa Individual and Family plan at the same time. This does not apply to Children.

Eligibility changes and qualifying events

Certain events may require you to change who's covered by this Policy. These events include:

- Active duty in the military of an eligible child or spouse
- Appointment as a legal guardian of a child
- Birth or adoption of a child
- Care of a foster child (when placed in your home by an approved agency)
- Completion of full-time schooling of an eligible child
- Death
- Divorce, annulment or legal separation
- Exhaustion of COBRA coverage
- Marriage
- Spouse or child loses eligibility for qualifying dental coverage, i.e., employer or group sponsor stops contributing to qualifying dental plan. In this case, your spouse or child would be eligible for coverage under this Policy.
- Spouse's or Child's Medicaid, or Children's Health Insurance Program (CHIP) (i.e. Healthy and Well Kids in Iowa "Hawki") coverage is terminated as a result of losing eligibility or the Covered Person becomes eligible for a premium assistance subsidy under Medicaid or CHIP. You need to request coverage within 60 days of losing coverage or 60 days from when eligibility for premium assistance is determined.

Notification of change

You must notify us within 60 days of the date of the event that changes the status of your eligibility. If a change to your eligibility isn't made within 60 days of the event, the person(s) affected may lose coverage.

Please note: You must notify us when there is a change in your marital status (i.e. divorce or legal separation) or a

Child loses eligibility status.

Authorized policy changes

No agent, employee, or representative of ours is authorized to change or waive any of the provisions of this Policy. This Policy may only be changed when we:

- Need to make changes to comply with federal or state laws. When this happens, we'll automatically amend this Policy to comply.
- Send you a written amendment signed by an authorized officer and accepted by you as shown by payment of the monthly premium.
- Receive proper notice that your marital or eligibility status has changed.

Premiums

You must pay the full amount of your premium by the due date. Payment must be made before the 1st of each calendar month. You can pay by automatic withdrawal (ACH) from a checking or savings account or with a valid credit card (i.e., American Express, Discover, MasterCard or Visa).

When coverage begins

Your coverage under this Policy starts on your Policy Effective Date. Before you receive benefits under this Policy, you must allow any healthcare provider to give us information about a treatment or condition for which we are being billed. If we don't get the information requested (or if you withhold information in your application), you may not get coverage and benefits may be denied.

If you give us false or misleading information, conceal important details in your application or use the benefits in this Policy in a fraudulent manner, we may end (terminate) your benefits.

When coverage ends

Your coverage will end (terminate) on the last day of the month following any of these events. You become ineligible for coverage under this Policy if:

- You decide to discontinue, terminate, or replace this coverage. Note, you need to notify us in writing at least 20-days before you want to end coverage.
- We decide to end coverage of all similar policies by giving you written notice at least 90 days before it will end.
- You're no longer a permanent resident of Iowa.

Your coverage will end (terminate if any of the following happens:

- You use this Policy fraudulently. Note: We may recover any claims payments we made, minus any premiums you paid.
- You fraudulently misrepresent or hide important facts in your application. Note: We'll recover any claim payments we made, minus any premiums you paid.
- You don't pay your premium when it's due.

Effects of termination

If your coverage is terminated for fraud, misrepresentation or the concealment of material facts:

- We won't pay for any services or supplies provided after the date the coverage is terminated.
- We'll keep legal rights—including the right to initiate a civil action.
- We may declare the coverage void.

If your coverage is terminated for reasons other than fraud, concealment or misrepresentation of material facts, we'll stop benefits the day your coverage is terminated.

If you're totally disabled and a covered loss happens while this Policy is in force, and continues after this Policy is terminated, your benefits for the covered loss will be available after the Policy terminates. However, your benefits will be limited to the Policy's Benefit Period Maximum payable for the loss—and only until the end of the Benefit Period (which is a calendar year).

If you change from one Delta Dental of Iowa Individual and Family plan to another Delta Dental of Iowa Individual and Family plan during your Benefit Period, your benefits will not re-start with the new plan. Benefits used on the first or existing plan will be accumulated and rolled over to the new plan.

Our right to recover payments

Payment in Error

If for any reason we make payment under this Policy in error, we may recover the amount we paid.

Subrogation

Once you receive benefits under this Policy due to an illness or injury, we'll assume any legal right you have to collect any payment related to the illness or injury. That includes benefits from:

- The responsible person's insurer.
- Uninsured or underinsured motorist coverage.
- Other insurance coverage.

You agree to all of the following: That you will:

- Let us know about any potential claims or rights of recovery related to the illness or injury.
- Give us any information or help we need to enforce our rights under this Policy.
- Not do anything to prejudice our rights and interests.
- Not compromise, settle, surrender or release any claim or right of recovery described above without our written permission.
- Reimburse us for benefit payments made under this Policy, if you get paid from the other party.
- Let us know if you may have the right to receive payment from someone else.
- Cooperate with us to make sure our rights to subrogation are protected.

Other information notice

You can send any notice to our home office:

Delta Dental of Iowa
P.O. Box 9010
Johnston, IA 50131-9010

Any notice from us to you is valid when sent to the address we have for you in our records.

Nonassignment

Benefits in this Policy are for you. They can't be transferred or assigned to anyone else without our written permission.

Governing law

This Policy will be interpreted in accordance with and governed by the laws of the state of Iowa, unless any federal laws supersede state laws. Any action brought because of a claim under this Policy will be litigated exclusively in the state or federal courts located in the state of Iowa and in no other.

Legal action

No legal or equitable action may be brought against us because of a claim under this Policy, or because of the

alleged breach of this Policy, more than two years after the end of the calendar year in which the services or supplies were provided.

For people enrolled in Medicaid
This Policy will pay benefits for Covered Services to you, or any other person who has been legally assigned the right to receive such benefits under Title XIX of the Social Security Act (Medicaid).

Enrollment without regard to Medicaid or CHIP
Your receipt or eligibility for medical assistance under Title XIX of the Social Security Act (Medicaid or CHIP) will not affect your enrollment as a Covered Person(s) under this Policy. It also won't affect our determination of any benefits paid to you.

Third-Party liability for Medicaid payments
If payment has been made by Medicaid, and we have a legal obligation to provide benefits for those services, we'll pay those benefits in accordance with the terms of this Policy and any state law under which a state acquires the right to such payments.

Payer of Last Resort
If you are covered by this Policy and one or more Government-sponsored healthcare or dental programs, such as Medicaid (DWP) or CHIP (Hawki) during the same Benefit Period as this Policy, federal and state law requires this Policy to provide benefits first (or as primary) and the Government-sponsored healthcare/dental programs to provide benefits second (or secondary). If you have coverage from all three of these types of policies at the same time (which is rare, but sometimes happens); the order of benefit processing and payments will be this Policy, then Hawki and then Medicaid.

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full nondiscrimination notice go to www.deltadentalia.com/nondiscrimination.

Delta Dental of Iowa

P.O. Box 9000

Johnston, IA 50131-9000

Hearing Impaired Toll Free: 1-888-287-7312
Toll Free: 1-800-544-0718
Local: 1-515-261-5500

www.deltadentalia.com
Claims@deltadentalia.com
IndividualProduct@deltadentalia.com

DELTA DENTAL®

Required Federal Notice-Nondiscrimination and Accessibility

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full nondiscrimination notice go to www.deltadentalia.com/nondiscrimination.

Delta Dental of Iowa provides free language services to people who's primary language is not English. In addition, Delta Dental provides free services for people with disabilities such as auxiliary aids, written communication in other formats such as large print, audio or other formats. If you need these services, call 1-877-423-3582 x3, hearing impaired (TYY) call 1-888-287-7312.

Language Access Service

If you, or someone you're helping, has questions about Delta Dental of Iowa, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-423-3582 x3.

Arabic –

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Delta Dental of Iowa، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-423-3582 x3.

Chinese – 如果您，或是您正在協助的對象，有關於 Delta Dental of Iowa 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請致電 1-877-423-3582 x3

French – Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Delta Dental of Iowa, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-423-3582 x3.

German – Falls Sie oder jemand, dem Sie helfen, Fragen zum Delta Dental of Iowa haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-423-3582 x3 an.

Hindi – यदि आपके, या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के Delta Dental of Iowa के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुभाषिए से बात करने के लिए 1-877-423-3582 x3 पर कॉल करें।

Karen – နၢ, မ့တမ့ၢ် ပှၤတဂၤဂၤလၢနမၢစၢၤအိၢ,
မ့ၢ်အိဉ်ဒီး တၢ်သံကွၢ်တဖဉ်ဘဉ်ယးဒီးDelta Dental of Iowa နှဉ်,နအိဉ်ဒီး တၢ်ခွဲးတၢ်ယာ်လၢနကဒီးန့ၢ်ဘဉ်တၢ်မၤစၢၤဒီး တၢ်ဂ့ၢ်တၢ်ကျိၤလၢ နကျိာ်ဒဉ် နဲလၢ တလိဉ်ဟ့ဉ်အပူၤဘဉ်နှဉ်လီၤ. လၢနက
ကတိၤတၢ်ဒီး ပှၤကတိၤကျိာ်ထံတၢ်အဂိၢ်, ကိး1-877-423-3582 x3တက့ၢ်.

Korean – 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Delta Dental of Iowa에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-423-3582 x3로 전화하십시오.

Laotian – ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Delta Dental of Iowa, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-877-423-3582 x3.

Pennsylvania Dutch: Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Delta Dental of Iowa, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-877-423-3582 x3 uffrufe.

Russian – Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Delta Dental of Iowa, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-423-3582 x3.

Serbo-Croatian – Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Delta Dental of Iowa, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-423-3582 x3.

Spanish – Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental of Iowa, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-423-3582 x3.

Tagalog – Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Delta Dental of Iowa, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-423-3582 x3.

Thai – หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Delta Dental of Iowa คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-877-423-3582 x3

Vietnamese – Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Delta Dental of Iowa, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-423-3582 x3.

Delta Dental of Iowa

DELTA DENTAL PPO PLUS PREMIER®

INDIVIDUAL CHOICE - PREVENTIVE PLUS

REQUIRED OUTLINE OF COVERAGE

A. **Read Your Policy Carefully**. This Outline of Coverage provides a very brief description of some important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of you, your dentist and Delta Dental of Iowa. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

This is a certified Stand Alone Dental plan in the Health Insurance Marketplace.

B. This dental plan is designed to provide an Eligible Covered Person, who is over age 21 as of January 1, with coverage for diagnostic and preventive benefits. This dental plan is also designed to provide an Eligible Covered Person, who is under age 21 as of January 1, with comprehensive care related to pediatric essential health benefits.

C. **BENEFITS** - The information in the two charts below summarizes your benefits and payment obligations.

Adult Chart –This chart is for all Eligible Covered Persons age 21 and older as of January 1st.

You receive benefits from the categories below:	From a type of dentist below	You pay the applicable deductible for the benefits? (Yes/No)	You pay the Coinsurance percentage below	The benefits used count against the Benefit Period Maximum? (Yes/No)
Benefit Categories	**Type of Network**	**Your Deductible***	**Member Coinsurance****	**Benefit Period Maximum or Annual Maximum*****
	PPO	$50		No Limit
	Premier	$50		
	Non-par	$75		
Check-ups and teeth cleanings (Diagnostic and Preventive)	PPO	Yes	20%	Yes
	Premier	Yes	30%	Yes
	Non-par	Yes	50%	Yes
Cavity repair and tooth extractions (Routine and Restorative Services)	PPO	Yes	50%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	70%	Yes
Posterior composite(s) (Tooth-colored filling(s) on back teeth)	PPO	Yes	50%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	70%	Yes

*Deductible is per person, paid once per Benefit Period.

Member Coinsurance is the percent of costs ***you pay* each time you receive certain covered services.

Benefit Period Maximum or Annual Maximum is the maximum dollar amount ***we'll pay for all Covered Services for each Covered Person (Adult) under the Policy in a Benefit Period.

Child Chart - This chart is for all Eligible Covered Persons under age 21 as of January 1.

You receive benefits from the categories below:	From a type of dentist below	You pay the applicable Deductible for the benefits? (Yes/No)	You pay the Coinsurance percentage below	The amounts you pay count towards the MOOP? (Yes/No)
Benefit Categories	**Type of Network**	**Your Deductible***	**Member Coinsurance****	**Maximum Out of Pocket Limit (MOOP)*****
	PPO	$25		[$375/$750]
	Premier	$25		[$375/$750]
	Non-par	$225		n/a
Check-ups and teeth cleanings (Diagnostic and Preventive)	PPO	No	0%	Yes
	Premier	No	0%	Yes
	Non-par	No	50%	No
Cavity repair and tooth extractions (Routine and Restorative Services)	PPO	Yes	20%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	70%	No
Posterior composite(s) (Tooth-colored filling(s) on back teeth)	PPO	Yes	60%	Yes
	Premier	Yes	60%	Yes
	Non-par	Yes	70%	No
Root canals (Endodontic Services)	PPO	Yes	50%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	70%	No
Gum and bone disease (Periodontal Services)	PPO	Yes	50%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	70%	No
High-cost restorations (Restorations)	PPO	Yes	50%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	70%	No
Dentures and bridges (Prosthetics)	PPO	Yes	50%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	70%	No
Dental implants (Prosthetics)	PPO	Yes	60%	Yes
	Premier	Yes	60%	Yes
	Non-par	Yes	70%	No
Straighter teeth (Medically Necessary Orthodontics)	PPO	No	50%	Yes
	Premier	No	50%	Yes
	Non-par	No	50%	No

*Deductible is per person, paid once per Benefit Period.

** Member Coinsurance is the percentage of costs ***you pay*** each time you receive certain covered services.

*** The Maximum Out of Pocket Limit ("MOOP") is the maximum dollar amount ***you will pay*** for all covered services, including Deductibles and Coinsurance. The MOOP for any one Child is $375 in a Benefit Period and $750 for all Children in a Benefit Period.

D. LIMITATIONS – Adult

1. **Dental Cleaning (Prophylaxis)** - *Limitation:* Routine dental cleaning is a benefit only twice per Benefit Period.

2. **Oral Evaluations -** *Limitation:* These evaluations/examinations/consultations are a benefit only twice per Benefit Period.

3. **Bitewing X-Rays -** *Limitation:* For an Eligible Covered Person, who is age 21 or older as of the Anniversary Date, bitewing x-rays are a benefit once every 24 consecutive months if there is no history of restorations in the previous 24 months. If there is a history of restorations in the previous 24 months, bitewing x-rays are a benefit once every 12 consecutive months.

4. **Cone Beam CT X-Rays** – *Limitation:* This procedure is a benefit once per Benefit Period.

5. **Full-Mouth X-Rays -** *Limitation:* Full-mouth x-rays are a benefit only once every 5 consecutive years.

6. **Occlusal and Extraoral X-Rays -** *Limitation:* These x-rays are a benefit only once every 12 consecutive months.

7. **Restoration of Decayed or Fractured Teeth** – *Limitation:* Restorations are a benefit once every 24 months per tooth.

8. **Limited Occlusal Adjustment** - *Limitation:* Limited Occlusal Adjustment is a benefit only twice every 12 consecutive months.

E. EXCLUSIONS – Adult – Even if the treatment is not specifically listed as an exclusion, it may not be covered under this Policy. Call us if you are unsure if a certain service is covered.

1. **Anesthesia or Analgesia -** You are not covered for general anesthesia, intravenous sedation, local anesthesia, non-intravenous conscious sedation, or nitrous oxide (relative analgesia).

2. **Broken Appointments -** You are not covered for any fees charged by your dental office because of broken appointments.

3. **Complete Occlusal Adjustment** - You are not covered for services or supplies used for revision or alteration of the functional relationships between upper and lower teeth.

4. **Complications of a Non-Covered Procedure** - You are not covered for complications of a non- covered procedure.

5. **Congenital Deformities** - You are not covered for services or supplies to correct congenital deformities, such as a cleft palate.

6. **Controlled Release Device** - You are not covered for services or supplies used for the controlled release of therapeutic agents into diseased crevices around your teeth.

7. **Cosmetic in Nature** - You are not covered for services or supplies which have the primary purpose of improving the appearance of your teeth, rather than restoring or improving dental form or function.

8. **Desensitizing Medicament or Resin -** You are not covered for the application of desensitizing medicament or resin for cervical and/or root surface sensitivity either on a per tooth or per visit basis.

9. **Drugs -** You are not covered for prescription, non-prescription drugs, medicines or therapeutic drug injections.

10. **Effective Date -** You are not covered for services or supplies received before the effective date of coverage under this Policy.

11. **Experimental or Investigative -** You are not covered for services or supplies that are considered experimental, investigative or have a poor prognosis. Peer reviewed outcomes data from clinical trials, Food and Drug Administration regulatory status, and established governmental and professional guidelines will be used in this determination.

12. **Extraoral X-Rays** – Adults are not covered for Extraoral X-Rays.

13. **Government Programs -** You are not covered for services or supplies when you are entitled to claim benefits from governmental programs (except Medicaid).

14. **Gum and Bone Diseases (Periodontal Services)** – You are not covered for services or supplies for periodontal services including conservative, complex, or maintenance periodontal procedures.

15. **High Cost Restorations (Cast Restorations)** – You are not covered for services or supplies for cast restoration services, including crowns, inlays, and onlays.

16. **Implants -** You are not covered for any dental implants which are surgically placed in the jawbone. You are also not covered for the attachment of any device to a surgically placed implant in the jawbone.

17. **Incomplete Services -** You are not covered for dental services that have not been completed.

18. **Indirect Pulp Caps -** You are not covered for indirect pulp caps.

19. **Infection Control -** You are not covered for separate charges for “infection control,” which includes the costs for services and supplies associated with sterilization procedures. Delta Dental Dentists incorporate these costs into their normal fees and will not charge an additional fee for “infection control.”

20. **Lost or Stolen Appliances -** You are not covered for services or supplies required to replace lost or stolen dental appliances.

21. **Medical Services or Supplies -** You are not covered for services or supplies which are medical in nature, including dental services performed in a hospital, treatment of fractures and dislocations, treatment of cysts and malignancies, and accidental injuries.

22. **Military Service -** You are not covered for services or supplies which are required to treat

an illness or injury received while you are on active status in the military services. However, upon written request, you may ask for a refund of premiums that you have paid while on active military status.

23. **Oral Surgery -** You are not covered for oral surgery including removal of teeth, and other surgical services to the teeth.

24. **Payment Responsibility** - You are not covered for services or supplies when someone else has the legal obligation to pay for your care, and when, in the absence of this Policy, you would not be charged.

25. **Periodontal Appliances -** You are not covered for services or supplies for periodontal appliances (bite guards) to reduce bite (occlusal) trauma due to tooth grinding or jaw clenching.

26. **Periodontal Splinting -** You are not covered for services or supplies used for the primary purpose of reducing tooth mobility, including crown-type restorations.

27. **Plaque Control Programs, Oral Hygiene Instructions, and Dietary Instructions** – You are not covered for services or supplies used for plaque control, oral hygiene, and/or dietary instructions.

28. **Policy Termination** - Whether or not we have approved a treatment plan, you are not covered for treatment received after the coverage termination date of this Policy.

29. **Prosthetics (Bridges, Dentures, and Dental Implants)** – You are not covered for services or supplies used for prosthetics including bridges, dentures, and dental implants.

30. **Provisional Crowns, Bridges or Dentures** - You are not covered for services or supplies for provisional crowns, bridges or dentures.

31. **Repair, Replacement or Duplication of Orthodontic Appliances** - You are not covered for services or supplies required to repair, replace or duplicate any orthodontic appliance.

32. **Root Canals (Endodontics) -** You are not covered for endodontic services including apicoectomy/periradicular surgery, direct and indirect pulp cap, pulpotomy, retrograde fillings, or root canal therapy

33. **Sales Tax and Fees** – We do not pay sales tax or fees billed by dentists for dental services.

34. **Sealants/Preventive Resin Applications** - You are not covered for services or supplies for sealant/preventive resin applications.

35. **Services Not Reimbursed to Some Extent by Delta Dental** – You are not covered for any services that otherwise would qualify as Covered Service but which Delta Dental does not reimburse to some extent. This may include services not reimbursed because of applicable deductibles, copayments, coinsurance, benefit maximums, waiting periods, and frequency limitations.

36. **Services Provided in Other Than Office Setting -** You are not covered for services provided in other than a dental office setting.

37. **Space Maintainers** – You are not covered for space maintainers for missing back teeth or the removal of fixed space maintainers.

38. **Specialized Services -** You are not covered for specialized, personalized, elective materials and techniques or technology which are not reasonably necessary for the diagnosis or treatment of dental disease or dysfunction. Specialized services represent enhancements to other services and are considered optional.

39. **Straighter Teeth** – **Corrective Orthodontics** – You are not covered for Corrective Orthodontics. Corrective Orthodontic services are orthodontic procedures, or directly associated procedures, that move teeth to correct an abnormal dental relationship between and among teeth.

40. **Straighter Teeth** – **Medically Necessary Orthodontics** – You are not covered for Medically Necessary Orthodontic services. Medically Necessary Orthodontic services are orthodontic procedures benefited because of needed orthognathic surgery, certain designated syndromes of genetic disorders such as cleft palate.

41. **Temporary or Interim Procedures** - You are not covered for temporary or interim procedures.

42. **Temporomandibular Joint Dysfunction (TMD) -** You are not covered for expenses incurred for diagnostic x-rays, appliances, restorations or surgery in connection with Temporomandibular Joint Dysfunction or myofunctional therapy.

43. **Tooth Extractions –** You are not covered for tooth extractions.

44. **Treatment by Other than a Licensed Dentist -** You are not covered for services or treatment performed by anyone other than a licensed dentist or his or her employees.

45. **Treatment in Process** – You may not be covered for services or supplies related to treatment which began prior to the effective date of this certification.

46. **Unerupted Teeth -** You are not covered for the prophylactic removal of unerupted teeth (asymptomatic and nonpathological). This means we will not pay for the removal of any tooth that is not visible and not causing harm.

47. **Workers' Compensation -** You are not covered for services or supplies that are or could have been compensated under Workers' Compensation laws, including services or supplies applied toward satisfaction of any Deductible under your employer's Workers' Compensation coverage.

F. LIMITATIONS – Child

1. **Dental Cleaning (Prophylaxis)** – *Limitation:* Routine dental cleaning is a benefit only twice per Benefit Period.

2. **Oral Evaluations –** *Limitation*: These evaluations/examinations/consultations are a benefit only twice per Benefit Period.

3. **Topical Fluoride Applications –** *Limitation:* Topical fluoride is a benefit only twice per Benefit Period.

4. **Bitewing X-Rays –** *Limitation:* Bitewing x-rays are a benefit only twice per Benefit Period.

5. **Cone Beam CT X-Rays** – *Limitation:* This procedure is a benefit once per Benefit Period.

6. **Full-Mouth X-Rays –** *Limitation:* Full-mouth x-rays or panoramic x-rays are a benefit only once every 5 consecutive years.

7. **Occlusal and Extraoral X-Rays –** *Limitation:* These x-rays are a benefit only once every 12 consecutive months.

8. **Periodontal Maintenance Therapy** – *Limitation:* This procedure may follow conservative or complex periodontal therapy; benefits are available up to four times in the first Benefit Period; and, up to four times in the next Benefit Period; and twice per Benefit Period thereafter. This procedure replaces the dental cleaning benefit (prophylaxis) described earlier in this section.

9. **Sealant/Preventive Resin Applications** – *Limitation:* Sealant/Preventive Resin applications are a benefit once per permanent first and second molars every 24 consecutive months. Sealants and Preventive Resins for primary teeth, wisdom teeth, or teeth that have already been treated with a restoration are not a benefit.

10. **Non-Surgical Periodontal Procedures (Root Planing and Scaling) -** *Limitation:* Non-Surgical periodontal procedures are a benefit only once every 24 consecutive months for each quadrant of the mouth.

    Note: A quadrant is one of the four equal sections of the mouth into which the jaws can be divided and represents four or more contiguous teeth or bounded teeth spaces.

11. **Denture Adjustments -** *Limitation:* Denture Adjustments will be limited to two per denture per Benefit Period after 6 months have elapsed since initial placement.

12. **Denture Rebase / Relining -** *Limitation:* Rebase and relining are available only if performed 6 months or more after the initial placement of the denture then once every 3 consecutive years thereafter.

13. **General Anesthesia/Sedation –** *Limitation:* General anesthesia and intravenous sedation are benefits only when provided in conjunction with covered oral surgery and when billed by the operating dentist.

14. **Restoration of Decayed or Fractured Teeth** – *Limitation:* Stainless steel crowns are a benefit for an Eligible Covered Person, who is under age 15 as of January 1 of the Benefit Period, once per tooth every 5 consecutive years.

15. **Tissue Conditioning -** *Limitation:* Tissue conditioning will be limited to two per denture every 36 consecutive months.

16. **Root Canal Therapy –** *Limitation:* Pulpal Therapy is limited to once per tooth per lifetime.

17. **Athletic Mouth Guard** – *Limitation:* An athletic mouth guard is a benefit for all eligible Covered Persons under age 19 once every 24 consecutive months.

18. **Full Mouth Debridement** – *Limitation:* Full mouth debridement is a benefit once in a lifetime after 36 months have elapsed since last dental cleaning (prophylaxis).

19. **Surgical Periodontal Procedures** – *Limitation:* Surgical periodontal procedures are a benefit only once every 3 consecutive years for each tooth/quadrant of the mouth for natural teeth only. In addition, **you should receive Delta Dental's review before this service is performed.**

Note: A quadrant is one of the four equal sections of the mouth into which the jaws can be divided and represents four or more contiguous teeth or bounded teeth spaces.

20. **Periodontal Appliances –** *Limitation:* Periodontal appliance is a benefit only for an eligible Child age 13 to 20 years of age as of January 1 of the Benefit Period, once per Benefit Period. In addition, **you should receive Delta Dental's review before this service is performed.**

21. **Cast Restorations for Complicated Tooth Decay or Fracture** – *Limitation:* Available once every 5 consecutive years beginning from the date the cast restoration is cemented in place.

22. **Crowns** – *Limitation:* Crowns are a benefit only if the tooth cannot be restored with a routine filling. Benefit is available once every 5 consecutive years beginning from the date the cast restoration is cemented in place. In addition, **you should receive Delta Dental's review before this service is performed.**

23. **Inlays** – *Limitation:* Inlay benefits are limited to the amount paid for a silver (amalgam) filling and available once every 5 consecutive years beginning from the date the cast restoration is cemented in place.

24. **Onlays** – *Limitation:* Benefit is available once every 5 consecutive years beginning from the date the cast restoration is cemented in place.

25. **Posts and Cores** – *Limitation:* Benefit is available once every 5 consecutive years beginning from the date the cast restoration is cemented in place.

26. **Recementation of Restorations** – *Limitation:* This procedure is a benefit once every 12 months after 6 months have elapsed since initial placement.

27. **Bridges** – *Limitation:* Bridges (prosthetics) are a benefit once every 5 consecutive years. In addition, **you should receive Delta Dental's review before this service is performed.**

28. **Dentures (Complete and Partial)** – *Limitation:* Dentures (prosthetics) are a benefit once every 5 consecutive years. In addition, **you should receive Delta Dental's review before this service is performed.**

29. **Dental Implants** – *Limitation:* Dental implants are a benefit once every 5 consecutive years. In addition, **you should receive Delta Dental's review before this service is performed.**

30. **Straighter Teeth – Medically Necessary** Orthodontics - *Limitation:* Medically Necessary Orthodontic services for proper alignment of teeth are a benefit only for an Eligible Covered Person, who is under age 21. ***Medically Necessary"*** Orthodontic is orthodontic procedures and Covered Services benefited because of needed orthognathic surgery, certain designated syndromes or genetic disorders such as cleft palate. **Please Note: Medically Necessary Orthodontics *REQUIRES* our review and approval before treatment begins.** Benefits received from 'Medically Necessary'

Orthodontics may apply to the Maximum Out Of Pocket.

G. EXCLUSIONS – Child - Even if the treatment is not specifically listed as an exclusion, it may not be covered under this Policy. Call us if you are unsure if a certain service is covered.

1. **Anesthesia or Analgesia -** You are not covered for local anesthesia, nitrous oxide (relative analgesia), or non-intravenous conscious sedation when billed separately from the related procedure.

2. **Broken Appointments -** You are not covered for any fees charged by your dental office because of broken appointments.

3. **Complete Occlusal Adjustment** - You are not covered for services or supplies used for revision or alteration of the functional relationships between upper and lower teeth.

4. **Complications of a Non-Covered Procedure** - You are not covered for complications of a non- covered procedure.

5. **Congenital Deformities** - You are not covered for services or supplies to correct congenital deformities, unless you qualify under Medically Necessary Orthodontics.

6. **Cosmetic in Nature** - You are not covered for services or supplies which have the primary purpose of improving the appearance of your teeth, rather than restoring or improving dental form or function.

7. **Desensitizing Medicament or Resin -** You are not covered for the application of desensitizing medicament or resin for cervical and/or root surface sensitivity either on a per tooth or per visit basis.

8. **Drugs -** You are not covered for prescription, non-prescription drugs, or medicines.

9. **Effective Date -** You are not covered for services or supplies received before the effective date of coverage under this Policy.

10. **Experimental or Investigative -** You are not covered for services or supplies that are considered experimental, investigative or have a poor prognosis. Peer reviewed outcomes data from clinical trials, Food and Drug Administration regulatory status, and established governmental and professional guidelines will be used in this determination.

11. **Government Programs -** You are not covered for services or supplies when you are entitled to claim benefits from governmental programs (except Medicaid).

12. **Incomplete Services -** You are not covered for dental services that have not been completed.

13. **Indirect Pulp Caps -** You are not covered for indirect pulp caps.

14. **Infection Control -** You are not covered for separate charges for “infection control,” which includes the costs for services and supplies associated with sterilization procedures. Delta Dental Dentists incorporate these costs into their normal fees and will not charge an additional fee for “infection control.”

15. **Limited Occlusal Adjustment** – You are not covered for limited occlusal adjustment.

16. **Lost or Stolen Appliances -** You are not covered for services or supplies required to replace lost or stolen dental appliances.

17. **Medical Services or Supplies -** You are not covered for services or supplies which are medical in nature, including dental services performed in a hospital, treatment of fractures and dislocations, treatment of cysts and malignancies, and accidental injuries.

18. **Military Service -** You are not covered for services or supplies which are required to treat an illness or injury received while you are on active status in the military services.

19. **Payment Responsibility** - You are not covered for services or supplies when someone else has the legal obligation to pay for your care, and when, in the absence of this Policy, you would n**o**t be charged.

20. **Periodontal Appliances -** An Eligible Covered Person, who is under 13 or over 20 years of age as of January 1, is not covered for services or supplies for periodontal appliances (bite guards) to reduce bite (occlusal) trauma due to tooth grinding or jaw clenching

21. **Periodontal Splinting -** You are not covered for services or supplies used for the primary purpose of reducing tooth mobility, including crown-type restorations.

22. **Plaque Control Programs, Oral Hygiene Instructions, and Dietary Instructions** – You are not covered for services or supplies used for plaque control, oral hygiene, and/or dietary instructions.

23. **Policy Termination -** Whether or not we have approved a treatment plan, you are not covered for treatment received after the coverage termination date of this Policy.

24. **Provisional Crowns, Bridges or Dentures** - You are not covered for services or supplies for provisional crowns, bridges or dentures.

25. **Repair, Replacement or Duplication of Orthodontic Appliances** - You are not covered for services or supplies required to repair, replace or duplicate any orthodontic appliance.

26. **Sales Tax and Fees** – We do not pay sales tax or fees billed by dentists for dental services.

27. **Services Not Reimbursed to Some Extent by Delta Dental –** You are not covered for any services that otherwise would qualify as Covered Service but which Delta Dental does not reimburse to some extent. This may include services not reimbursed because of applicable deductibles, copayments, coinsurance, benefit maximums, waiting periods, and frequency limitations.

28. **Services Provided in Other Than Office Setting -** You are not covered for services provided in other than a dental office setting.

29. **Space Maintainer Removal –** You are not covered for the removal of fixed space maintainers.

30. **Specialized Services -** You are not covered for specialized, personalized, elective materials and techniques or technology which are not reasonably necessary for the

diagnosis or treatment of dental disease or dysfunction. Specialized services represent enhancements to other services and are considered optional.

31. **Straighter Teeth – Corrective Orthodontics –** You are not covered for Corrective Orthodontics. Corrective Orthodontic services are orthodontic procedures, or directly associated procedures, that move teeth to correct an abnormal dental relationship between and among teeth.

32. **Straighter Teeth – Medically Necessary Orthodontics –** An Eligible Covered Person, who is age 21 or older as of January 1, is not covered for Medically Necessary Orthodontics.

33. **Temporary or Interim Procedures** - You are not covered for temporary or interim procedures.

34. **Temporomandibular Joint Dysfunction (TMD) -** You are not covered for expenses incurred for diagnostic x-rays, appliances, restorations or surgery in connection with Temporomandibular Joint Dysfunction or myofunctional therapy.

35. **Treatment by Other than a Licensed Dentist -** You are not covered for services or treatment performed by anyone other than a licensed dentist or his or her employees.

36. **Treatment in Progress** – You may not be covered for services or supplies related to treatment which began prior to the effective of this policy.

37. **Unerupted Teeth -** You are not covered for the prophylactic removal of unerupted teeth (asymptomatic and nonpathological). This means we will not pay for the removal of any tooth that is not visible and not causing harm.

38. **Workers' Compensation -** You are not covered for services or supplies that are or could have been compensated under Workers' Compensation laws, including services or supplies applied toward satisfaction of any Deductible under your employer's Workers' Compensation coverage.

H. POLICY RENEWAL – Your coverage under the Policy will continue unless one of the following events occurs:

1. You fail to make your premium payment to us when due.
2. You become ineligible for coverage under the Policy.
3. You decide to discontinue or replace this coverage - *Delta Dental of Iowa requires at least **20-day written** notice prior to the requested termination.*
4. We decide to terminate coverage of all similar Policies by giving written notice to you 90 days prior to termination.
5. You use the Policy fraudulently or you fraudulently misrepresent or conceal material facts in your application. If this happens, we will recover any claim payments we made, minus any premiums paid.
6. You are no longer a permanent resident of Iowa.

I. PREMIUMS – You must pay us the full amount of your premium in advance of the due date assigned for your Policy. For example, payment must be made prior to the beginning of each calendar month, via automatic withdrawal (ACH) from a checking or savings account or with a valid credit card (American Express, Discover Card, Master Card, or VISA).

J. OTHER INFORMATION –

Claims filing address – Delta Dental of Iowa; P.O. Box 9000; Johnston, IA 50131-9000
Hearing Impaired Toll Free – 1 – 888 – 287- 7312
Toll Free – 1 – 800 – 544 – 0718 **Local** – 1– 515 – 261 – 5500
Delta Dental of Iowa's website –

- www.deltadentalia.com
- claims@deltadentalia.com
- individualproduct@deltadentalia.com

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full nondiscrimination notice go to http://www.deltadentalia.com/nondiscrimination .