Notice of 10-Day Right to Examine Contract: If after examining this Policy you are not satisfied with the Policy terms for any reason, you may return the Policy within 10 days of delivery and upon return, we will refund any premiums paid**.**

DELTA DENTAL PPO PLUS PREMIER®

INDIVIDUAL CHOICE –

PREVENTIVE PLUS

MEMBER POLICY

NOTE: Your coverage under the Policy will continue unless one of the following events occurs: 1) You fail to make your premium payment when due each month; 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 a 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.

Individual Choice - Preventive Plus
Print Date: 01/01/2018
Form Number: INDPREVP –01012018

INTERPRETING THIS POLICY

It is important that you understand all parts of this Policy to get the most out of your coverage. To help make the information easier to understand, we use the words *you* and *your* to refer to you and your other Eligible Covered Persons who qualify for coverage under this Policy. *We*, *us*, and *our* refer to Delta Dental of Iowa.

We will interpret the provisions of this Policy and determine the answer to all questions that arise under it. We have the administrative discretion to determine whether you meet our written eligibility requirements, or to interpret any other term in this Policy. If any benefit in this Policy is subject to a determination of dental necessity and dental appropriateness, we will make that factual determination. Our interpretations and determinations are final and conclusive.

In this Policy we sometimes refer to certain laws and regulations. Laws and regulations can and do change from time to time. If you have a question as to how laws and regulations may apply to your Policy, please contact us.

To administer your benefits properly, there are certain rules you must follow. Different rules appear in different sections of your Policy. We urge you to become familiar with the entire Policy.

This Policy is a certified Qualified Health Plan in the Health Insurance Marketplace.

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SUMMARY OF BENEFITS AND PAYMENT

The information on the following 2 charts summarizes your benefits and payment obligations. For a detailed description of specific benefits and benefit limitations, see the IMPORTANT INFORMATION and BENEFITS sections of this Policy

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

	DEDUCTIBLE APPLIES*	MEMBER COINSURANCE	ANNUAL MAXIMIUM APPLIES
Benefit Categories	$50 PPO $50 Premier $75 Non Par		Unlimited
Check-ups and Teeth Cleanings (Diagnostic and Preventive)	Yes	20% - PPO 30% - Premier 50% - Non Par	Yes
Cavity Repair (Routine and Restorative Services)	Yes	50% - PPO 50% - Premier 70% - Non Par	Yes

***Deductible is per Eligible Covered Person per Benefit Period.**

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

	DEDUCTIBLE APPLIES*	MEMBER COINSURANCE	MAXIMUM OUT OF POCKET APPLIES**
Benefit Categories	$25 PPO $25 Premier $225 Non Par		$350 / $700 – PPO and Premier N/A – Non Par
Check-ups and Teeth Cleanings (Diagnostic and Preventive)	No	00% - PPO 00% - Premier 50% - Non Par	Yes
Cavity Repair and Tooth Extractions (Routine and Restorative Services)	Yes	20% - PPO 50% - Premier 70% - Non Par	Yes
Posterior Composites (Tooth-colored filling on back teeth)	Yes	60% - PPO 60% - Premier 70% - Non Par	Yes
Root Canals (Endodontic Services)	Yes	50% - PPO 50% - Premier 70% - Non Par	Yes
Gum and Bone Disease (Periodontal Services)	Yes	50% - PPO 50% - Premier 70% - Non Par	Yes
High Cost Restorations (Cast Restorations)	Yes	50% - PPO 50% - Premier 70% - Non Par	Yes
Dentures and Bridges (Prosthetics)	Yes	50% - PPO 50% - Premier 70% - Non Par	Yes
Dental Implants (Prosthetics)	Yes	60% - PPO 60% - Premier 70% - Non Par	Yes
Straighter Teeth – Medically Necessary Orthodontics	Yes	50% - PPO 50% - Premier 50% - Non Par	Yes

*Deductible is per Eligible Covered Person per Benefit Period.

**Maximum Out Of Pocket is per eligible Child with a maximum amount for all eligible covered children for PPO Panel Dentists and/or Participating Delta Dental Dentists (Premier).

IMPORTANT INFORMATION

Your Delta Dental PPO[SM] coverage is administered by Delta Dental of Iowa. By encouraging preventive care, this dental program is designed to help contain dental costs. The key component of the Delta Dental PPO Program is our panel of Delta Dental PPO Dentists hereafter referred to as "PPO Panel Dentists." You may seek care from almost any dentist you wish. However, there are usually advantages when you receive services from PPO Panel Dentists or Participating Delta Dental Dentists. "Participating Delta Dental Dentists," in this Policy, are dentists who participate with Delta Dental of Iowa's Premier Program or their local Delta Dental Member Company's Premier Program, but do not participate as a PPO Panel Dentist.

Your payment responsibilities are also outlined in this section of your Policy. How much you pay for Covered Services depends on the benefit category of the service you receive and the dentist you receive services from. It is most often to your financial advantage to receive services from a PPO Panel Dentist or a Participating Delta Dental Dentist.

WHAT YOU SHOULD KNOW ABOUT PPO PANEL DENTISTS

We have contracting relationships with PPO Panel Dentists throughout the state. Our contracts with PPO Panel Dentists include a PPO Schedule. See UNDERSTANDING PAYMENT VOCABULARY later in this section. This PPO Schedule usually results in savings to you. When you receive services from PPO Panel Dentists who participate with Delta Dental of Iowa or any other Delta Dental Member Company, all of the following statements are true:

- PPO Panel Dentists agree to accept their local Delta Dental Member Company's PPO Schedule, which may result in savings for Covered Services.
- Your Deductible or Member Coinsurance responsibility may be *less* for Covered Services you receive from a PPO Panel Dentist than it would be from a Participating Delta Dental Dentist or a nonparticipating dentist.
- PPO Panel Dentists agree to file claims for you.
- We settle claims directly with PPO Panel Dentists. See UNDERSTANDING AMOUNTS YOU PAY TO SHARE COSTS later in this section.
- PPO Panel Dentists agree to handle the Treatment Plan Pre-Determinations for you. See the TREATMENT PLAN PRE-DETERMINATION section.
- PPO Panel Dentists agree that he or she will only be paid the lesser of (i) his or her Billed Charge or (ii) Delta Dental's PPO Schedule for Covered Services. **Important:** This does not apply in the situation where a service otherwise qualifying as a Covered Service is provided and Delta Dental does not reimburse any part of such service. In such situation, the PPO Panel Dentist is not limited in the amount of the payment he or she may collect from you. See UNDERSTANDING PAYMENT VOCABULARY later in this section.

WHAT YOU SHOULD KNOW ABOUT PARTICIPATING DELTA DENTAL DENTISTS

We have contracting relationships with Participating Delta Dental Dentists throughout the state. Our contracts with Participating Delta Dental Dentists include payment arrangements based on Delta Dental's Maximum Plan Allowance. See UNDERSTANDING PAYMENT VOCABULARY later in this section. The Maximum Plan Allowance usually results in savings to you. When you receive services from Participating Delta Dental Dentists who participate with Delta Dental of Iowa or a Delta Dental Member Company, all of the following statements are true:

- Participating Delta Dental Dentists agree to accept their local Delta Dental Member Company's payment arrangements, which may result in savings for Covered Services.

- Your Deductible or Member Coinsurance responsibility may be *more* for Covered Services you receive from a Participating Delta Dental Dentist who is not a PPO Panel Dentist.
- Participating Delta Dental Dentists agree to file claims for you.
- We settle claims directly with Participating Delta Dental Dentists. See UNDERSTANDING AMOUNTS YOU PAY TO SHARE COSTS later in this section.
- Participating Delta Dental Dentists agree to handle the Treatment Plan Pre-Determination for you. See TREATMENT PLAN PRE-DETERMINATION section.
- Participating Delta Dental Dentists agree that he or she will only be paid the lesser of (i) his or her Billed Charge or (ii) Delta Dental's Maximum Plan Allowance for Covered Services. **Important:** This does not apply in the situation where a service otherwise qualifying as a Covered Service is provided and Delta Dental does not reimburse any part of such service. In such situation, the Participating Delta Dental Dentist is not limited in the amount of the payment he or she may collect from you. See UNDERSTANDING PAYMENT VOCABULARY later in this section.

WHAT YOU SHOULD KNOW ABOUT DENTISTS WHO DO NOT PARTICIPATE WITH DELTA DENTAL

When you receive services from nonparticipating (non-par) dentists, you will not receive any of the advantages that our contracts with PPO Panel Dentists or Participating Delta Dental Dentists offer. As a result, when you receive services from nonparticipating dentists, all of the following statements are true:

- We do not have contracting relationships with nonparticipating dentists and they do not agree to accept their local Delta Dental Member Company's PPO payment arrangement or any other payment arrangement. This means you are responsible for any difference between your nonparticipating dentist's Billed Charge and the PPO Schedule or the Maximum Plan Allowance, as the case may be. See UNDERSTANDING PAYMENT VOCABULARY later in this section.
- Nonparticipating dentists are not responsible for filing your claims.
- We settle claims with you, not nonparticipating dentists. You are responsible for paying your dentist in full, including any Deductible, Member Coinsurance and non-approved charges you may owe. See UNDERSTANDING PAYMENT VOCABULARY later in this section.
- Nonparticipating dentists do not agree to handle the Treatment Plan Pre-Determination for you. See TREATMENT PLAN PRE-DETERMINATION section.
- Nonparticipating dentists may charge for "infection control," which includes the cost for services and supplies associated with sterilization procedures. You are responsible for any extra charges billed by a nonparticipating dentist for "infection control." (All dentists are legally required to follow certain guidelines to protect their patients and staff from exposure to infection. However, PPO Panel Dentists and Participating Delta Dental Dentists incorporate these costs into their normal fees and do not charge an additional fee for "infection control.")
- Nonparticipating dentists do not agree that he or she will only be paid the lesser of (i) his or her Billed Charge or (ii) Delta Dental's PPO Schedule for Covered Services, as do PPO Panel Dentists in certain situations. See UNDERSTANDING PAYMENT VOCABULARY later in this section.
- Nonparticipating dentists do not agree that he or she will only be paid the lesser of (i) his or her Billed Charge or (ii) Delta Dental's Maximum Plan Allowance for Covered Services, as do Participating Delta Dental Dentists in certain situations. See UNDERSTANDING PAYMENT VOCABULARY later in this section.

QUESTIONS WE ASK WHEN YOU RECEIVE DENTAL CARE

Even though a procedure may appear in a given section such as BENEFITS, you should note that before you are eligible to receive benefits, we first answer all of the following questions:

Is the Procedure Dentally Necessary?

All of the following must be true for a procedure to be considered 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 the following must be true for a procedure to be considered dentally appropriate:

- The treatment is the most appropriate procedure for your individual circumstances; and
- The treatment is consistent with and meets professionally recognized standards of dental care and complies with criteria adopted by us; and
- The treatment is not more costly than alternative procedures that would be equally effective for the treatment or maintenance of your teeth and their supporting structures. **If you receive services which are more costly than those equally effective for the treatment or maintenance of your teeth and supporting structures, you are responsible for paying the difference.**

Is the Procedure Subject to Contract Limitations?

Contract limitations refer to amounts that are your responsibility based on your contractual obligations with us. Examples of contract limitations may include the following:

- Amounts for procedures that are not dentally necessary or dentally appropriate.
- Amounts for procedures that are not covered by this Policy. See SERVICES NOT COVERED section.
- Amounts for procedures that have limitations associated with them. For example, teeth cleaning is covered twice per Benefit Period. More frequent teeth cleaning may not be a benefit even if your dentist verifies that it is 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 contract 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 PPO Schedule or the Maximum Plan Allowance, as the case may be. ***Please note:*** This only applies if you receive services from a nonparticipating dentist or services from a PPO Panel Dentist or a Participating Delta Dental Dentist that are not reimbursed by Delta Dental to some extent.
- Deductible(s) and Member Coinsurance.

OUR PAYMENT POLICY

Our Policy is to send our payment for treatment after it is completed—not before. For example, we will send our payment for:

- A crown when it is seated.
- A fixed or removable prosthesis when it is inserted.
- A root canal when it is filled.

UNDERSTANDING PAYMENT VOCABULARY

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. This is true for as long as you have coverage. The Benefit Period is important for calculating 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.

Contract Period Effective Date

Contract Period Effective Date is the first day the dental coverage was in effect between you and Delta Dental of Iowa.

Covered Services

Covered Services means dental services allowed as a result of being insured by, or included under a dental plan administered by, Delta Dental of Iowa (or by a Delta Dental Member Company).

Delta Dental Member Company

Delta Dental Member Company means a company that is an active member or affiliate member of Delta Dental Plans Association, as defined in the Delta Dental Plans Associations Bylaws.

Eligible Covered Person(s)

Eligible 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)

Spouse means your husband or wife as the result of a marriage that is legally recognized in Iowa. Your domestic partner may be an Eligible Covered Person. A domestic partner is a person of the same or opposite sex, whom has shared a permanent residence with you for more than one year, is no less than 18 years of age, is not a blood relative any closer than would prohibit legal marriage in Iowa, you do not qualify for coverage under common law marriage, and you are not legally married to anyone in the state in which you reside.

An eligible Child can be your natural child, a child placed with you for adoption or a legally adopted child, a child for whom you have legal guardianship, a stepchild, or a foster child. A child who has been placed in your home for the purpose of adoption or whom you have adopted shall be eligible for coverage as of the date of placement for adoption or as of the date of actual adoption, whichever occurs first.

- An **Adult** Eligible Covered Person may be:
    - You, the policyholder;
    - Your eligible Spouse or domestic partner;
    - An Adult Child who is age or older as of January 1;
- A **Child** Eligible Covered Person may be:
    - A Child who is under age 21 as of January 1.

Maximum Plan Allowance

Maximum Plan Allowance is the amount which Delta Dental establishes as its maximum allowable fee for the dental services under the Delta Dental Premier Program. For services billed by dentists outside of Iowa, the Maximum Plan Allowance is based on information from that state's Delta Dental Member Company.

The Maximum Plan Allowance is established by Delta Dental for dental services contained in the "Current Dental Terminology" published by the American Dental Association from time to time. It is developed from various sources that may include, but are 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 and with similar training and skills, and a leading economic indicator, such as the Consumer Price Index.

PPO Schedule

The PPO Schedule is a reduced fee schedule for certain Covered Services. Some Participating Delta Dental Dentists, who are other than general practice dentists, will be considered PPO Panel Dentists except that their payment will be based on the lesser of their Billed Charge or the Maximum Plan Allowance rather than on the PPO Schedule. The Participating Delta Dental Dentists who have agreed to be PPO Panel Dentists will be listed in the Delta Dental of Iowa PPO Panel Dentist Directory, unless they are dentists outside of Iowa.

UNDERSTANDING AMOUNTS *YOU PAY* TO SHARE COSTS

Deductible

Deductible is the fixed dollar amount you pay for Covered Services for each Eligible Covered Person in a Benefit Period before benefits are available under this Delta Dental Policy. This amount is shown on the SUMMARY OF BENEFITS AND PAYMENT charts at the beginning of this Policy, if applicable.

Please note: Deductible is per Eligible Covered Person per Benefit Period.

Member Coinsurance

Member Coinsurance is the amount, calculated using a fixed percentage, you pay each time you receive certain Covered Services. These amounts are shown on the SUMMARY OF BENEFITS AND PAYMENT charts at the beginning of this Policy.

Member Coinsurance payments begin once you meet any applicable Deductible amounts. Member Coinsurance is calculated off the PPO Schedule or the Maximum Plan Allowance, as the case may be. In general, the percentage of Member Coinsurance you pay depends on the benefit category of the service you receive and participation status of your dentist.

Benefit Period Maximum or Annual Maximum

The Benefit Period Maximum or Annual Maximum is the maximum benefit each Covered Person is eligible to receive for certain Covered Services in a Benefit Period. The Benefit Period Maximum is reached from claims settled under this Policy in a Benefit Period. This amount is shown on the SUMMARY OF BENEFITS AND PAYMENT charts at the beginning of this Policy, if applicable.

Maximum Out Of Pocket

Maximum Out Of Pocket is the maximum amount you pay per Benefit Period for certain Covered Services for Deductible and Member Coinsurance. This amount is shown on the SUMMARY OF BENEFITS AND PAYMENT charts at the beginning of this Policy, if applicable.

Once the Maximum Out Of Pocket is satisfied, most Covered Services (benefit limitations will still apply) are covered in-full through the end of the Benefit Period.

Please Note: There is no Maximum Out Of Pocket limit for Covered Services provided by dentists who do not participate in the Delta Dental (or a Delta Dental Member Company) network(s).

Other Payment Responsibilities

In addition to the above, you will be responsible for any charge made by a dentist, even if it is a PPO Panel Dentist or a Participating Delta Dental Dentist, where Delta Dental has not reimbursed to some extent any of the charge because you have not met any applicable waiting periods or deductibles and/or have exceeded any applicable benefit maximum or frequency limitation.

HELP WHEN YOU HAVE QUESTIONS

If you have any questions after reading this Policy, please call us. For your convenience, we have listed our toll-free number on the back cover of this Policy.

BENEFITS - Adults

CHECK-UPS AND TEETH CLEANING
(DIAGNOSTIC AND PREVENTIVE SERVICES)

Dental Cleaning (Prophylaxis)
Removing plaque, tartar (calculus), and stain from teeth.
Limitation: Dental cleaning is a benefit only twice per Benefit Period.

Oral Evaluations
Limitation: This evaluation is a benefit only twice per Benefit Period.

X-Rays:
Bitewing X-Rays
Bitewing is an x-ray that shows the crowns of the upper and lower teeth simultaneously and that is held in place by a tab between the teeth.
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.

Full-Mouth X-Rays
Full-mouth x-rays include 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 performed within 5 consecutive years of the panoramic x-ray.
Limitation: Full-mouth x-rays are a benefit only once every 5 consecutive years.

Occlusal and Extraoral X-Rays
Occlusal x-rays capture all the upper and lower teeth in one image while the film rests on the biting surface of the teeth.
Limitation: These x-rays are a benefit only once every 12 consecutive months.

Periapical X-Rays
A radiographic image of a tooth, or limited number of teeth, that includes the crown and root portions.

CAVITY REPAIR
ROUTINE AND RESTORATIVE SERVICES

Emergency Treatment (Palliative Treatment)
Treatment to relieve pain or infection of dental origin.

Restoration of Decayed or Fractured Teeth
Pre-formed or stainless steel restorations and restorations such as silver (amalgam) fillings, and tooth-colored (composite) fillings.

Limited Occlusal Adjustment
Reshaping the biting surfaces of one or more teeth.
Limitation: Limited Occlusal Adjustment is a benefit only twice every 12 consecutive months.

SERVICES NOT COVERED - Adult

This Delta Dental Policy does not provide benefits for dental treatment listed in this section. **Please note:** 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. For your convenience, we have listed our toll-free number on the back cover of this Policy.

POLICY EXCLUSIONS

Anesthesia or Analgesia

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

Broken Appointments

You are not covered for any fees charged by your dental office because of broken appointments.

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.

Complications of a Non-Covered Procedure

You are not covered for complications of a non-covered procedure.

Congenital Deformities

You are not covered for services or supplies to correct congenital deformities, such as a 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

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.

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.

Drugs

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

Effective Date

You are not covered for services or supplies received before the effective date of coverage under this Policy.

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.

Government Programs

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

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

You are not covered for dental services that have not been completed.

Indirect Pulp Caps

You are not covered for indirect pulp caps.

Infection Control

You are not covered for separate charges for "infection control," which includes the costs for services and supplies associated with sterilization procedure Delta Dental Dentists incorporate these costs into their normal fees and will not charge an additional fee for "infection control."

Lost or Stolen Appliances

You are not covered for services or supplies required to replace lost or stolen dental appliances.

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.

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.

Oral Surgery

You are not covered for oral surgery including removal of teeth, and other surgical services to the teeth.

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.

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

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

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.

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.

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

You are not covered for services or supplies for provisional crowns, bridges or dentures.

Repair, Replacement or Duplication of Orthodontic Appliances

You are not covered for services or supplies required to repair, replace or duplicate any orthodontic appliance.

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.

Sealant/Preventive Resin Applications

You are not covered for services or supplies for sealant/preventive resin applications.

Services Not Reimbursed to Some Extent by Delta Dental

You are not covered for any service 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.

Services Provided in Other Than Office Setting

You are not covered for services provided in other than a dental office setting.

Space Maintainers

You are not covered for space maintainers for missing back teeth or for the removal of fixed space maintainers.

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.

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.

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.

Temporary or Interim Procedures

You are not covered for temporary or interim procedures.

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.

Tooth Extractions

You are not covered for tooth extractions.

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.

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.

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.

BENEFITS – Child

CHECK-UPS AND TEETH CLEANING (DIAGNOSTIC AND PREVENTIVE SERVICES)

Dental Cleaning (Prophylaxis)

Removing plaque, tartar (calculus), and stain from teeth.
Limitation: Routine dental cleaning is a benefit only twice per Benefit Period.

Diagnostic Cast

Diagnostic cast is a replica of the teeth and tissues made from an impression; also called a study model.

Emergency Treatment (Palliative Treatment)

Treatment to relieve pain or infection of dental origin.

Oral Evaluations

Limitation: This evaluation is a benefit only twice per Benefit Period.

Topical Fluoride Applications

Professionally administered procedure in which the dental surfaces are coated with a fluoride solution or gel to discourage decay.
Limitation: Topical fluoride is a benefit only twice per Benefit Period.

X-Rays:

Bitewing X-Rays

Bitewing is an x-ray that shows the crowns of the upper and lower teeth simultaneously and that is held in place by a tab between the teeth.

Limitation: Bitewing x-rays are a benefit only twice per Benefit Period.

Full-Mouth X-Rays

Full-mouth x-rays include 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 performed within 5 consecutive years of the panoramic x-ray.
Limitation: Full-mouth x-rays are a benefit only once every 5 consecutive years.

Occlusal and Extraoral X-Rays

Occlusal x-rays capture all the upper and lower teeth in one image while the film rests on the biting surface of the teeth.
Limitation: These x-rays are a benefit only once every 12 consecutive months.

Periapical X-Rays

A radiographic image of a tooth, or limited number of teeth, that includes the crown and root portions.

Periodontal Maintenance Therapy

Includes various maintenance services such as pocket depth measurements, dental cleaning (oral prophylaxis), removal of stain, and root planing and scaling.
Limitation: This procedure may follow conservative or complex periodontal therapy. When this procedure immediately follows complex or conservative periodontal therapy; benefits are available up to four times in the first Benefit Period and twice per Benefit Period thereafter. *This procedure replaces the dental cleaning benefit (prophylaxis) described under* Check-Ups and Teeth Cleaning *earlier in this section.*

Sealant/Preventive Resin Applications

Filling decay-prone areas of the chewing surface of molars.
Limitation: Sealant/Preventive Resin applications are a benefit once per permanent first and second molars every 36 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.

Space Maintainers for Missing Back Teeth

Space maintainers are passive appliances designed to prevent tooth movement.

CAVITY REPAIR AND TOOTH EXTRACTIONS (ROUTINE AND RESTORATIVE SERVICES)

Conservative Periodontal Procedures (Root Planing and Scaling)

Removing contaminants such as bacterial plaque and tartar (calculus) from a tooth root to prevent or treat disease of the gum tissues and bone which support it.
Limitation: Conservative 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.

Consultations

A diagnostic service provided by a dentist where the dentist and patient discuss the patient's dental needs and proposed treatment.

Denture Adjustments

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

Denture Rebase / Relining

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

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.

Pulpotomy

Removing the coronal portion of the pulp as part of root canal therapy. When performed on a baby (primary) tooth, pulpotomy is the only procedure required for root canal therapy.

Restoration of Decayed or Fractured Teeth

Pre-formed or stainless steel restorations and restorations such as silver (amalgam) fillings, and tooth-colored (composite) fillings.

Limitation: Stainless steel crowns are a benefit for an Eligible Covered Person, who is under age 15 as of January 1, once per tooth every 5 consecutive years.

Routine Oral Surgery

Routine oral surgery includes the removal of teeth, and other surgical services to the teeth or immediate surrounding hard and soft tissues that are being performed due to disease, pathology, or dysfunction of dental origin.

Therapeutic Drug Injection

Therapeutic drug injection includes a single administration of antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications.

Tissue Conditioning

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

ROOT CANALS
(ENDODONTIC SERVICES)

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 promote healing 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. This procedure generally involves removal of the pulp and replacement with an inert filling material.

Limitation: Pulpal Therapy is limited to once per tooth per lifetime.

GUM AND BONE DISEASES
(PERIODONTAL SERVICES)

Please note: Procedures in this category should receive our review *before* they are performed. See the TREATMENT PLAN PRE-DETERMINATION section.

Alveoloplasty
Surgical procedure for recontouring supporting bone, sometimes in preparation for a prosthesis.

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

Complex Periodontal Procedures
Various surgical interventions designed to repair and regenerate gum and bone tissues that support the teeth.
Limitation: Complex periodontal procedures are a benefit only once every 36 consecutive months for each 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 and represents four or more contiguous teeth or bounded teeth spaces.

Guided Tissue Regeneration
Services and supplies for regeneration of lost periodontal structures.

Periodontal Appliance
Removable dental appliance, which is designed to minimize the effects of bruxism (grinding) and tongue thrust.
Limitation: Periodontal appliance is a benefit only for an Eligible Covered Person, who is 13 to 20 years of age as of January 1, once per Benefit Period.

HIGH COST RESTORATIONS
(CAST RESTORATIONS)

Please note: Procedures in this category should receive our review *before* they are performed. See the TREATMENT PLAN PRE-DETERMINATION section.

Procedures in this category are available once every 5 consecutive years beginning from the date the cast restoration is cemented in place.

Cast Restorations for Complicated Tooth Decay or Fracture
Restoring a tooth with a cast filling (including local anesthesia) when the tooth cannot be restored with a silver (amalgam) or tooth-colored (composite) filling.

Crowns
Restoring form and function by covering and replacing the visible part of the tooth with a precious metal, porcelain-fused-to-metal, or porcelain crown. *Crowns placed for the primary purpose of 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. Limitation:* Crowns are a benefit only if the tooth cannot be restored with a routine filling.

Inlays

Restoring a tooth with a cast metallic or porcelain filling.
Limitation: **Inlay benefits are limited to the amount paid for a silver (amalgam) filling.**

Onlays

Replacing one or more missing or damaged biting cusps of a tooth with a cast restoration.

Posts and Cores

Preparing a tooth for a cast restoration after a root canal when there is insufficient strength and retention.

Recementation of Cast Restorations

Recementation of an inlay, onlay, or crown that has become loose.

DENTURES AND BRIDGES (PROSTHETICS)

Please note: Procedures in this category should receive our review *before* they are performed. See the TREATMENT PLAN PRE-DETERMINATION section.

Please note: Dentures, bridges, and dental implants (prosthetics) are a benefit once every 5 consecutive years.

Bridges

Replacing missing permanent teeth with a dental prosthesis that is cemented in place and can only be removed by a dentist. Also covered are bridge repairs.

Dentures (Complete and Partial)

Replacing missing permanent teeth with a dental prosthesis that is removable.

Dental Implants

Dental implants which are surgically placed in the jaw bone, including attachment of devices to a surgically placed implant in the jaw.

STRAIGHTER TEETH – Medically Necessary Orthodontics

Medically Necessary Orthodontic services are orthodontic procedures 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. See the TREATMENT PLAN PRE-DETERMINATION section.**
Benefits received for Medically Necessary Orthodontics may apply to the Maximum Out Of Pocket.
Limitation: Medically Necessary Orthodontic services for proper alignment of teeth are a benefit only for an Eligible Covered Person, who is under age 21.

When an orthodontic treatment plan is established, Delta Dental of Iowa will calculate an initial payment at the time the banding takes place. The balance of the allowed fee will then be divided into payments over the course of treatment, providing coverage still exists.

If Medically Necessary orthodontic treatment is stopped for any reason before it is completed, Delta Dental of Iowa will pay only for Medically Necessary Orthodontic services and supplies actually received.

No benefits are available for charges made after treatment stops or after the termination of coverage.

Delta Dental of Iowa payment for treatment in progress extends only to the months of treatment received while covered under the plan. Delta Dental of Iowa will determine the months eligible for coverage.

Diagnostic Cast

Diagnostic cast is a replica of the teeth and tissues made from an impression; also called a study model.

SERVICES NOT COVERED - Child

This Delta Dental Policy does not provide benefits for dental treatment listed in this section. **Please note:** 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. For your convenience, we have listed our toll-free number on the back cover of this Policy.

POLICY EXCLUSIONS

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.

Broken Appointments

You are not covered for any fees charged by your dental office because of broken appointments.

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.

Complications of a Non-Covered Procedure

You are not covered for complications of a non-covered procedure.

Congenital Deformities

You are not covered for services or supplies to correct congenital deformities; unless you qualify under Medically Necessary Orthodontics.

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.

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.

Drugs

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

Effective Date

You are not covered for services or supplies received before the effective date of coverage under this Policy.

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.

Government Programs

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

Incomplete Services

You are not covered for dental services that have not been completed.

Indirect Pulp Caps

You are not covered for indirect pulp caps.

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."

Limited Occlusal Adjustment

You are not covered for limited occlusal adjustment.

Lost or Stolen Appliances

You are not covered for services or supplies required to replace lost or stolen dental appliances.

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.

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.

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.

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.

Periodontal Splinting

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

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.

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.

Provisional Crowns, Bridges or Dentures

You are not covered for services or supplies for provisional crowns, bridges or dentures.

Repair, Replacement or Duplication of Orthodontic Appliances

You are not covered for services or supplies required to repair, replace or duplicate any orthodontic appliance.

Services Not Reimbursed to Some Extent by Delta Dental

You are not covered for any service 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.

Services Provided in Other Than Office Setting

You are not covered for services provided in other than a dental office setting.

Space Maintainer Removal

You are not covered for the removal of fixed space maintainers.

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.

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.

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.

Temporary or Interim Procedures

You are not covered for temporary or interim procedures.

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.

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.

Unerupted Teeth

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

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.

TREATMENT PLAN PRE-DETERMINATION

This section explains the Treatment Plan Pre-Determination you or your dentist should follow before you receive certain benefits available under this Policy. This pre-determination is the checks and balances of your dental coverage. It helps:

- Determine that services are dentally necessary and dentally appropriate;
- Confirm the benefits of your Policy.

THE APPROVAL

The purpose of the pre-determination is to help control the cost of your benefits — not to keep you from receiving dentally necessary and dentally appropriate treatment. Our review is based on the treatment plan submitted by your dentist.

You should notify us before you receive the following benefits:

- **Complex Periodontal Surgery**
- **High Cost Restorations including Crowns, Onlays, and Bridges**
- **Dental Implants**

Procedures that ***REQUIRE*** our review and approval before they are performed:

- **Orthodontics - Medically Necessary**

You should also notify us before you receive treatment from any benefit category that will exceed $300.

THE TREATMENT PLAN

A treatment plan describes the treatment your dentist has recommended for you and helps us determine if the procedure is a benefit of your Policy as well as dentally necessary and dentally appropriate.

When to Submit a Treatment Plan

You will need to file a treatment plan only if your dentist is nonparticipating—PPO Panel Dentists and Participating Delta Dental Dentists agree to file for you. A complete treatment plan includes the plan of treatment and x-rays. Please send the x-rays within 15 working days of receipt of the proposed treatment plan.

Where to Send a Treatment Plan

Submit the proposed treatment plan, along with x-rays and supporting information to:

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

THE TREATMENT PLAN REVIEW

Once we receive the treatment plan and proper documentation, we will let you and your dentist know if the treatment plan is approved within 15 working days. We will take one of the following three actions when we receive your treatment plan:

- *Accept* it as submitted.
- *Recommend an alternative benefit*. If we ask you to receive an independent diagnosis from a dentist of our choice, we will pay for the exam.
- *Deny the treatment plan* because:
  — the procedure is not a benefit of your Policy;
  — you did not receive an independent exam after we asked you to; or
  — the procedure is not dentally necessary and dentally appropriate.

Reconsideration Request of Treatment Plan

If we deny a treatment plan, you can resubmit it with additional documentation and ask us, in writing, to reconsider. If necessary, we will ask you to receive an independent diagnosis from an independent dentist of our choice—we will pay for the exam.

Please note: Although we may approve a treatment plan, we are not liable for the actual treatment you receive from your dentist.

FILING CLAIMS

Once you receive dental services, we need to receive a claim to determine the amount of your benefits. The claim lets us know the services you received, when you received them, and from which dentist. You will need to file a claim only when you use a nonparticipating dentist who does not agree to file a claim for you — PPO Panel Dentists and Participating Delta Dental Dentists file for you.

WHEN TO FILE YOUR CLAIM

After you receive services, you should file a claim only if your dentist has not filed one for you. Delta Dental may disallow payment of a claim submitted more than 365 days after the date services were rendered.

You should file a claim only *after* the procedure is completely finished. Do *not* file for payment before a procedure is completed.

If you need a claim form or have any questions after reading this section, please call us or visit our website www.deltadentalia.com. For your convenience, we have listed our toll-free number on the back cover of this Policy. If you must file your own claim, send it to the following address:

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

FILING WHEN YOU HAVE OTHER COVERAGE
COORDINATION OF BENEFITS

You may have other insurance or coverage that provides the same or similar benefit(s) as this Policy. If so, we will work with your other insurance company or carrier. The benefits payable under this Policy when combined with the benefits paid under your other coverage will not be more than 100 percent of either our payment arrangement amount or the other carrier's payment arrangement amount.

What You Should Do

When you receive services, you need to let us know that you have other coverage. Other coverage includes: group insurance, other group benefit plans (such as HMOs, PPOs, and self-insured programs); Medicare or

other governmental benefits; and the medical benefits coverage in your automobile insurance (whether issued on a fault or no-fault basis). To help us coordinate your benefits, you should:

- Inform your dentist by giving him or her information about your other coverage at the time you receive 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 by completing the appropriate boxes on the form. We will contact you if we need any additional information.

You must cooperate with us and provide requested information about your other coverage. If you do not give us necessary information, your claims will be denied.

What We Will Do

There are certain rules we follow to help us determine which Policy pays first when you have other insurance or coverage that provides the same or similar benefits as this Policy.
Here are some of the rules:

- The coverage *without coordination of benefits* pays first when both coverages are through a group sponsor such as an employer, but one coverage has coordination of benefits and one does not.
- The dental benefits of your *auto coverage* will pay before this coverage if the auto coverage does not have a coordination of benefits provision.
- The coverage which you have as *an employee or contract holder* pays before the coverage which you have as a Spouse or Child.
- The coverage you have as *the result of your active employment* pays before coverage you hold as a retiree or under which you are not actively employed.
- The coverage with the *earliest continuous effective date* pays first when none of the above rules apply.

If none of the guidelines just mentioned apply to your situation, we will use the Coordination of Benefits (COB) guidelines adopted by the Iowa Insurance Division to determine our payment to you or to your PPO Panel Dentist or Participating Delta Dental Dentist (as the case may be).

What You Should Know About Children

To coordinate benefits for a Child the following rules apply. For a Child who is:

- *Covered by both parents* who are not separated or divorced or if they are, neither parent has primary physical custody, the coverage of the parent whose birthday occurs first in a calendar year pays first. If another carrier does not use this rule, then the other plan will determine which coverage pays first.
- *Covered by separated or divorced parents* and a court decree says which parent has financial or dental insurance responsibility, that parent's coverage pays first.
- *Covered by separated or divorced parents* and a court decree does not stipulate which parent has financial or dental insurance responsibility, then the coverage of the parent with custody pays first. The payment order for this Child is as follows: custodial parent, Spouse of custodial parent, other parent, and Spouse of other parent.

If none of these rules apply, the parent's coverage with the earliest continuous effective date pays first.

APPEALING A DENIED CLAIM OR ADVERSE BENEFIT DETERMINATION

YOUR INITIAL REQUEST FOR A REVIEW

If Delta Dental does not pay all or part of your claim and you think the service should be covered, you or your representative can ask for a full and fair review of that claim. To file for a review, submit a request within 180 days of receiving the notice from Delta Dental, including the reason why you disagree with our claim decision, documents, records and any other information related to the claim. Include your name, patient's name and your identification number on all documents.

DELTA DENTAL'S REPLY

Within 30 days of receiving your request, Delta Dental will send you our written decision and indicate any action we have taken. However, when special circumstances arise, Delta Dental may require 60 days. Delta Dental will notify you in the event we require additional days. After that time, we will make the final decision on the claim based on the information we have in your file.

REVIEWING RECORDS

Upon your request, Delta Dental will provide you free of charge, access to and copies of all documents, records and other information relevant to your claim for benefits. You can review records that deal with your request from 8 a.m. to 4:30 p.m., Central Standard Time, Monday through Friday, at Delta Dental's Johnston, Iowa location. Since so many records are electronically filed, please call Delta Dental in advance so we can have copies ready for you.

Send your request to:

Delta Dental of Iowa
P.O. Box 9010
Johnston, Iowa 50131-9010
or call 1-800-544-0718

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've furnished you with a copy of the statement.

ANNUAL OPEN ENROLLMENT PERIOD

For Eligible Covered Persons enrolling through the Marketplace there is an annual open enrollment period which begins November 1 with benefits effective January 1.

ELIGIBILITY ENROLLMENT REQUIREMENTS

This Policy includes the following eligibility enrollment requirements:

- The Covered Person must be a permanent Iowa resident.
- The Covered Person must remain on one Delta Dental PPO Individual Dental Plan Policy for 12 consecutive months before switching to another plan Policy.
- If you drop coverage you will not be eligible to re-enroll in this or any other Delta Dental PPO Individual Plan Policy, for a period of 24 consecutive months, unless you have had continuous coverage with similar qualifying benefits.

ELIGIBILITY CHANGES
QUALIFYING EVENTS

Certain events may require you to change who is 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 or employer or group sponsor ceases contribution to qualifying dental coverage. In this case, your eligible Spouse and any eligible Children previously covered under the prior qualifying dental coverage are eligible for coverage under this Policy. **Spouse's Medicaid, or Child's Medicaid or Children's Health Insurance Program (CHIP) or Healthy And Well Kids in Iowa (hawk-i)** coverage is terminated as a result of losing eligibility **or** the Eligible Covered Person becomes eligible for a premium assistance subsidy under Medicaid or CHIP. This special enrollment opportunity is provided by the Children's Health Insurance Program Reauthorization Act (CHIPRA). You must request this special enrollment opportunity within 60 days of losing Medicaid, CHIP, or hawk-i coverage or within 60 days of when eligibility for the 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 is not made within 60 days of an event the person(s) affected may lose important coverage.

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).

WHEN COVERAGE BEGINS

Your coverage under this Policy begins on your effective date.

Please note: Before you receive benefits under this Policy, you have agreed in your application for coverage to release any necessary information requested about you so we can process claims for benefits. You must allow any healthcare provider or his or her employee to give us information about a treatment or condition. If we do not receive the information requested, or if you withhold information in your application, your benefits may be denied.

If you fraudulently use your identification card or misrepresent or conceal material facts in your application, then we may terminate your benefits.

WHEN COVERAGE ENDS

Your eligibility for coverage will terminate at the end of the month for any of these reasons:

- You become ineligible for coverage under this Policy.
- **You decide to discontinue or replace this coverage** - ***Delta Dental of Iowa requires at least a 20-day written notice prior to the requested termination***.
- We decide to terminate coverage of all similar Policies by giving written notice to you 90 days prior to termination.
- You are no longer a permanent resident of Iowa.

Your coverage will end if any of the following occurs:

- You use this 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.
- You fail to make premium payment to us when due.

Please note: You or your other Eligible Covered Person(s) are responsible for notifying us of a dissolution of marriage, legal separation or a Child losing eligibility status.

AUTHORIZED POLICY CHANGES

No agent, employee, or representative of ours is authorized to vary, add to, change, modify, waive, or alter any of the provisions of this Policy. This Policy cannot be changed except:

- *Upon the effective date of any final Federal or State regulations* that change or impact benefits and coverage limitations, this Agreement will automatically amend so that the obligations they impose on Delta Dental remain in compliance with such laws and/or standards.
- *By written amendment* signed by an authorized officer and accepted by you as shown by payment of the monthly premium.
- *By our receipt of proper notification* that your marital or eligibility status has..

EFFECTS OF TERMINATION

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

- *We will not pay* for any services or supplies provided after the date the coverage is terminated.
- We *will retain legal rights*. This includes the right to initiate a civil action based on fraud, concealment, or misrepresentation.
- We may, at our option, *declare the coverage void.*

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

If a covered loss commences while this Policy is in force, continues after termination of the Policy and if you are totally disabled when the covered loss commences, your benefits for the covered loss will continue after the Policy terminates, but will be limited to not more than the Policy's maximum benefits payable for the loss and only until the end of the Policy Benefit Period, which is a calendar year.

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 arising from an illness or injury, we will assume any legal right you have to collect compensation, damages, or any other payment related to the illness or injury, including benefits from any of the following:

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

You and your other Eligible Covered Person(s) agree to all of the following:

- You will let us know about any potential claims or rights of recovery related to the illness or injury;
- You will furnish any information and assistance that we determine we will need to enforce our rights under this Policy;
- You will do nothing to prejudice our rights and interests;
- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without getting our written permission;

- You must reimburse us to the extent of benefit payments made under this Policy if payment is received from the other party or parties;
- You and your other Eligible Covered Person(s) must notify us if you have the potential right to receive payment from someone else;
- You must cooperate with us to ensure that our rights to subrogation are protected.

OTHER INFORMATION

NOTICE

You may 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 your address as it appears on our records.

NONASSIGNMENT

Benefits for Covered Services in this Policy are for your personal benefit and cannot be transferred or assigned to anyone else without our consent. Any attempt to assign this Policy or rights to payment without our consent will be void.

GOVERNING LAW

To the extent not superseded by the laws of the United States, this Policy will be construed in accordance with and governed by the laws of the state of Iowa. 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.

INFORMATION IF YOU OR A MEMBER OF YOUR FAMILY IS ENROLLED IN MEDICAID

Assignment of Rights

This Policy will provide payment of benefits for Covered Services to you, your beneficiary, or any other person who has been legally assigned the right to receive such benefits under requirements established pursuant to Title XIX of the Social Security Act (Medicaid).

Enrollment Without Regard to Medicaid

Your receipt or eligibility for medical assistance under Title XIX of the Social Security Act (Medicaid) will not affect your enrollment as a participant or beneficiary of this Policy, nor will it affect our determination of any benefits paid to you.

Acquisition by States of Rights of Third Parties

If payment has been made by Medicaid and we have a legal obligation to provide benefits for those services, then we will make payment of those benefits in accordance with any state law under which a state acquires the right to such payments.

English	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 1-800-544-0718.
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 1-800-544-0718.
Chinese	如果您，或是您正在協助的對象，有關於[插入 SBM 項目的名稱 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，請撥電話 [在此插入數字 1-800-544-0718。
Vietnamese	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Delta Dental of Iowa, quý v ị 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 1-800-544-0718.
Serbo-Croation	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 1-800-544-0718.
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 1-800-544-0718 an.
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 اية تكلفة. للتحدث مع مترجم اتصل بـ 1-800-544-0718.
Laotian	ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Delta Dental of Iowa, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-800-544-0718.
Korean	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Delta Dental of Iowa 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-544-0718 로 전화하십시오.
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 , 1-800-544-0718 पर कॉल करें।
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 800-544-0718.
Pennsylvanian 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 1-800-544-0718 uffrufe.
Thai	หากคุณ หร□อคนท□□คุณดาล□□□□□□ห□□อม□คำถามเ ก□□ยวกบ□ Delta Dental of Iowa คุณ□สท□ ธ□ท□□□□□ด□ร□□ค□□□□□□□□□ห□□อและข□อมล□ ในภาษาของคุณ ได□โด□□□□ม□คาใช□□□าย พด□ คยกบลาม โทร 1-800-544-0718
Tagalog	Kung ikaw, o ang iyong tinutulangan, 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 1-800-544-0718
Karen	နၤ.မ့တမ့ါပှၤတဂၤဂၤလၢနမၤစၢၤအီၤ.မ့ါအိဉ်ဒီးတၢ်သံကွၢ်တဖဉ်ဘဉ်ယးဒီ Delta Dental of Iowa)နှဉ်.နအိဉ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၣ်ဘဉ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဇဉ်နဲလၢတလိဉ်ဟ့ဉ် အပူၤဘဉ်နှဉ်လီၤ.လၢနကကတိၤတၢ်ဒီးပှၤကတိၤကျိာ်ထံတၢ်အဂီၤ.ကိ 1-800-544-0718 ဒ)တက့ၢ်.
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 1-800-544-0718.

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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 Policy is a certified Qualified Health 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.**

	DEDUCTIBLE APPLIES*	**COINSURANCE**	**ANNUAL MAXIMUM APPLIES**
BENEFIT CATEGORIES	$50 PPO $50 Premier $75 Non-Par		Unlimited
Check-Ups and Teeth Cleaning (Diagnostic and Preventative Services)	Yes	20% - PPO 30% - Premier 50% - Non-Par	Yes
Cavity Repair (Routine and Restorative Services)	Yes	50% - PPO 50% - Premier 70% - Non-Par	Yes

*** Deductible is per Eligible Covered Person per Benefit Period.**

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

	DEDUCTIBLE APPLIES*	MEMBER COINSURANCE	MAXIMUM OUT OF POCKET APPLIES**
Benefit Categories	$25 PPO $25 Premier $225 Non Par		$350 / $700 – PPO and Premier N/A – Non Par
Check-ups and Teeth Cleanings (Diagnostic and Preventive)	No	00% - PPO 00% - Premier 50% - Non Par	Yes
Cavity Repair and Tooth Extractions (Routine and Restorative Services)	Yes	20% - PPO 50% - Premier 70% - Non Par	Yes
Posterior Composites (Tooth-colored filling on back teeth)	Yes	60% - PPO 60% - Premier 70% - Non Par	Yes
Root Canals (Endodontic Services)	Yes	50% - PPO 50% - Premier 70% - Non Par	Yes
Gum and Bone Disease (Periodontal Services)	Yes	50% - PPO 50% - Premier 70% - Non Par	Yes
High Cost Restorations (Cast Restorations)	Yes	50% - PPO 50% - Premier 70% - Non Par	Yes
Dentures and Bridges (Prosthetics)	Yes	50% - PPO 50% - Premier 70% - Non Par	Yes
Dental Implants (Prosthetics)	Yes	60% - PPO 60% - Premier 70% - Non Par	Yes
Straighter Teeth – Medically Necessary Orthodontics	Yes	50% - PPO 50 % - Premier 50% - Non Par	Yes

***Deductible is per Eligible Covered Person per Benefit Period.**

**Maximum Out Of Pocket is per eligible Child with a maximum amount for all eligible covered children for PPO Panel Dentists and/or Participating Delta Dental Dentists (Premier).

D. LIMITATIONS – Adult

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

2. **Oral Evaluations -** *Limitation*: This evaluation is 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. **Full-Mouth X-Rays -** *Limitation:* Full-mouth x-rays are a benefit only once every 5 consecutive years.

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

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

12. **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.

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

34. **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.

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

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

37. **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.

38. **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.

39. **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.

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

41. **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.

42. **Tissue Conditioning –** You are not covered for services or supplies pertaining to tissue conditioning.

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. **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.

46. **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*: This evaluation is 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. **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. **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 twice per Benefit Period thereafter. *This procedure replaces the dental cleaning benefit (prophylaxis) described earlier in this section.*

8. **Sealant/Preventive Resin Applications** – *Limitation:* Sealant/Preventive Resin applications are a benefit once per permanent first and second molars every 36 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.

9. **Conservative Periodontal Procedures (Root Planing and Scaling) -** *Limitation:* Conservative 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.

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

11. **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.

12. **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.

13. **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, once per tooth every 5 consecutive years.

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

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

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

17. **Complex Periodontal Procedures** – *Limitation:* Complex periodontal procedures are a benefit only once every 3 consecutive years for each 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.

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

19. **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.

20. **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.**

21. **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.

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

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

24. **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.**

25. **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.**

26. **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.**

27. **Straighter Teeth – Medically Necessary** - *Limitation:* Services for 'Medically Necessary' Orthodontic straightening of the teeth. ***"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. **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.

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

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

29. **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.

30. **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.

31. **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.

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

33. **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.

34. **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.

35. **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.

36. **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

K. Language Assistance -

English	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 1-800-544-0718.
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 اية تكلفة. للتحدث مع مترجم اتصل بـ 1-800-544-0718.
Chinese	如果您，或是您正在協助的對象，有關於[插入 SBM 項目的名稱 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，請撥電話 [在此插入數字 1-800-544-071
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 1-800-544-0718.
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 1-800-544-0718 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 ,1-800-544-0718 पर कॉल करें।
Karen	နၤ.မ့တမ့ၢ်ပှၤတဂၤဂၤလၢနမၤစၢၤဆီၤ.မ့ၢ်ဆိဉ်ဒီးတၢ်သံကွၢ်တဖဉ်ဘဉ်ဃးဒီ Delta Dental of Iowa)နှဉ်.နဆိဉ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၢ်ဘဉ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒဉ်နဲလၢတလိဉ်ဟ့ဉ် အပူၤဘဉ်နှဉ်လီၤ.လၢနကကတိၤတၢ်ဒီးပှၤကတိၤကျိာ်ထံတၢ်အဂီၢ်.ကိ 1-800-544-0718 ဒ)တက့ၢ်.
Korean	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Delta Dental of Iowa 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-544-0718 로 전화하십시오.
Laotian	ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Delta Dental of Iowa, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-800-544-0718.
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 1-800-544-0718.
Serbo-Croation	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 1-800-544-0718.
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 1-800-544-0718.
Tagalog	Kung ikaw, o ang iyong tinutulangan, 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 1-800-544-0718.
Thai	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Delta Dental of Iowa คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-800-544-0718

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 1-800-544-0718.

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 .