Certificate of Insurance

Dental Plan Description

Delta Dental Family – Low Plan

You may return this contract at any time within ten (10) days after its receipt by delivering or mailing it back to Delta Dental. Upon such delivery or mailing, the policy will be deemed void from the beginning, and any premium paid on it will be refunded. If you accept the terms and conditions of the contract, continue paying the premium. The contract will not be renewed if this dental program is no longer available.

Term and Renewal of Policy: This policy begins on the date shown as the Effective Date on the Contract Application and continues through the end of the calendar year (also referred to as the "Plan Year"). This policy is subject to the renewal requirements of the federally facilitated Health Insurance Marketplace. If you do not want the policy to be renewed, send written notice to the federally-facilitated Health Insurance Marketplace before the policy's renewal date. If you send notice not to renew, this policy will terminate on the last day of the current Plan Year. If we send you notice of non-renewal at least ninety (90) days before the end of the Plan Year, your policy will end on the last day of the Plan Year.

Notice to Buyer: This policy provides dental benefits only.

Northeast Delta Dental

Delta Dental Plan of Maine

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I. Welcome.

Welcome to Delta Dental! You are among the growing number of people receiving benefits through our Dental Care programs.

This Certificate of Insurance is issued by Delta Dental Plan of Maine and delivered in Maine. It describes the benefits of your program and tells you how to use your plan, please read it carefully. But, before you turn the page, we'd like you to know something about us...

Delta Dental is a not-for-profit organization which was established by Dentists to make Dental Care more open to the public.

Delta Dental is connected with Delta Dental Plans Association ("DDPA") which provides Dental Care programs in all states and U.S. territories.

Most Dentists in Maine participate with Delta Dental through Participating Agreements. Also, there is a network of Delta Dental Participating Dentists available to you across the nation.

Please take advantage of your Delta Dental plan. Good oral health is an important part of your overall health. You are encouraged to get your Dental Care from a Delta Dental PPO Dentist to benefit the most from your plan.

The dental benefits through this policy are governed by policies and procedures of the US Department of Health and Human Services ("HHS") and the Maine Bureau of Insurance (the "Maine Bureau"). This dental plan is offered through the federally-facilitated Health Insurance Marketplace (the "FFM"). Delta Dental intends to comply with the policies and procedures of the state and federal regulators in the offering and administration of this plan.

Your Coverage. The coverage for your dental plan uses Delta Dental's PPO network of Participating Dentists. This plan allows you to go to any Dentist of your choice and receive a level of benefits for covered services. You will receive the best value from your plan if you visit a Delta Dental PPO Dentist.

Delta Dental PPO Dentists are Participating Dentists who offer lower fees to their Delta Dental PPO patients. Delta Dental PPO Dentists are reimbursed by Delta Dental based on the lesser of the submitted charge or Delta Dental's allowed charge for PPO Dentists in the area in which the services were provided. PPO Dentists agree to accept Delta Dental's allowed charge for PPO Dentists as payment in full, and agree not to charge the difference between their fees and the amount paid by Delta Dental back to their Delta Dental patients. PPO Dentists are allowed to charge for Deductibles, Co-Payments, Coinsurance, or services not covered under your plan.

You will also receive benefits if you choose to visit a Delta Dental Premier Dentist. Delta Dental Premier Dentists are reimbursed by Delta Dental based on the lesser of the Dentist's charge or Delta Dental's allowed charge for PPO Dentists in the area in which the services were provided. You will be responsible for the difference in the cost of services between the "allowed charge" (based upon Delta Dental's allowance for PPO Dentists) and Delta Dental's allowed charge for Premier Dentists, in addition to any Deductible, Co-payment, and Coinsurance. Premier Dentists agree to accept this allowance for Premier Dentists as payment in full and agree not to charge the difference between their fees and the Premier allowance back to their Delta Dental patients. Payments you make to Premier Dentists do not count toward the Maximum Out-of-Pocket (MOOP) for Pediatric Enrollees.

Remember: All Delta Dental Participating Dentists agree to:

- File your claim forms for you.
- Charge you no more than the amount allowed by Delta Dental.
- Accept payment directly from Delta Dental.

You may choose to visit providers who are not Delta Dental PPO Dentists and who do not participate with Delta Dental as a Premier Dentist. Such providers are referred to as Non-Participating Dentists or Other Dental Providers (ODPs). You will receive benefits based on the lesser of the provider's charge or Delta Dental's allowed charge for Non-Participating Dentists or ODPs in the area in which the services were provided. The Non-Participating Dentist or ODP may bill up to their submitted charge. When there is not enough fee information for a dental procedure, Delta Dental will determine a fair payment amount. Any payments you make

to Non-Participating Dentists do not count toward the Maximum Out-of-Pocket (MOOP) for Pediatric Enrollees. You may be asked to bring a claim form to your visit. Claim forms can be found at www.nedelta.com or you may call 1-800-832-5700.

II. Definitions.

1. **Adult Enrollee.** Any person enrolled in the plan age nineteen (19) years or older as of the effective date of the plan.

2. **Agreement.** The contract between the Contract Holder and Delta Dental to provide dental benefits to Enrollees. The Agreement includes this document and the Contract Application.

3. **Co-Payments.** The amount of Dental Care cost you are required to pay due to the Office Visit Co-Pay.

4. **Coinsurance.** The amount of the Dental Care cost which you are required to pay after application of Coinsurance Percentages.

5. **Coinsurance Percentage.** The percentage covered by this dental plan for Diagnostic and Preventive Benefits (100%), Basic Restorative Benefits (60%), Major Restorative Benefits (50%), and Medically Necessary Orthodontia Benefits (50%).

6. **Contract Holder.** The individual named in the Contract Application.

7. **Coverage.** The Dental Care referred to in the Agreement.

8. **Coverage Period.** The period of coverage specified on the Contract Application.

9. **Deductible.** The portion of the charge for covered Dental Care which you or must pay before Delta Dental's payment responsibility begins. The Deductible for your Coverage is $150 per Enrollee per Plan Year.

10. **Delta Dental Plans Association (DDPA).** The association which comprises all of the Delta Dental Plans and affiliated organizations operating in the United States and its territories.

11. **Denied.** The fee for a procedure or service is not a benefit under the plan and is chargeable to the patient. The approved amount is not payable by Delta Dental, but is collectable from the patient.

12. **Dental Care.** The services usually provided by Dentists based on generally accepted standards of dental practice at the time the service is provided.

13. **Dental Plan Description (DPD).** This document which serves as your Certificate of Insurance. This DPD is part of the Agreement which names the terms and conditions for your dental plan.

14. **Dentist.** A person duly licensed to practice dentistry in the state in which the Dental Care is provided.

15. **Denturist.** A person licensed to practice denturism by the state in which the services are provided. The practice of denturism includes:

    (a) The taking of denture impressions and bite registration for the purpose of or with a view to the making, producing, reproducing, construction, finishing, supplying, altering or repairing of a complete maxillary (upper) or complete mandibular (lower) prosthetic denture, or both, to be fitted to an edentulous arch or arches;

    (b) The fitting of a complete maxillary (upper) or mandibular (lower) prosthetic denture, or both, to an edentulous arch or arches, including the making, producing, reproducing, constructing, finishing, supplying, altering and repairing of dentures; and

    (c) The procedures incidental to the procedures specified in paragraphs (a) and (b), as defined by the state licensing board.

    For the purpose of paying claims, licensed Denturists will be treated as an Other Dental Provider (ODP). Claims submitted by a Denturist must be accompanied by a copy of a certificate of good oral health that has been issued for the patient by a Dentist. A copy of the Denturist's license must be filed with Northeast Delta Dental before claims can be processed.

16. **Dependent.**

(a) The spouse to whom the Contract Holder is legally married.

(b) A child of the Contract Holder or a child of the spouse of the Contract Holder. A child can be by natural birth or legal adoption, a child in the process of adoption or guardianship and in the custody of the Contract Holder or the spouse of the Contract Holder, a foster child legally placed by order of a court or agency having competent jurisdiction, and/or a stepchild, under the age of twenty-six (26).

Qualified children are eligible regardless of student status and coverage will terminate when a child reaches the age of twenty-six (26). Children unable to care for themselves because of physical or mental disability are eligible regardless of age; supporting documentation from a health-care provider may be requested.

A newborn child is covered for the first thirty-one (31) days following birth. His/her coverage will continue if the child is enrolled within the first sixty (60) days following birth. The child may also be enrolled at any open enrollment or special enrollment period.

17. **Disallowed.** The fee for a procedure or service is not payable by Delta Dental, nor collectable from the patient by a Participating Dentist. The Exclusions and Limitations provisions in Section V list services which are Disallowed. In each instance, a Participating Dentist agrees not to charge a separate fee.

18. **Eligible Dependent(s).** Dependents who are eligible based on the Agreement and who are enrolled by the Subscriber as either Adult Enrollees or Pediatric Enrollees in the dental plan.

19. **Enrollees.** The Adult Enrollee(s) and the Pediatric Enrollee(s).

20. **Explanation of Benefits (EOB).** The notice which explains the benefits that were paid on your behalf. The EOB lets you know if any services are Denied or Disallowed, and gives you the reason(s) for the denial or disallowance.

21. **Maximum.** The Maximum dollar amount Delta Dental will pay for each Adult Enrollee in any Plan Year for covered benefits. The Maximum for each Adult Enrollee under this dental plan is $1,000 per Plan Year. All benefits paid, including benefits for Diagnostic and Preventive services, are counted toward an Adult Enrollee's Plan Year Maximum. The Maximum does not apply to Pediatric Enrollees.

22. **Maximum Out-of-Pocket (MOOP).** The maximum amount you have to pay for Co-Payments, Deductibles and Coinsurance for covered services on behalf of each Pediatric Enrollee. The MOOP for each Pediatric Enrollee under this dental plan is $350 per Plan Year up to a maximum for all Pediatric Enrollees in one family covered by this plan of $700 per Plan Year. The MOOP does not apply to Adult Enrollees.

23. **Medically Necessary Orthodontia.** Orthodontic services to correct handicapping malocclusions caused by cranio-facial orthopedic deformities involving the teeth. Examples of conditions causing such deformities include, but are not limited to, cleft palate, Treacher-Collins syndrome, Pierre-Robin syndrome, Marfan syndrome and Crouzon syndrome. Such conditions often require a combined pre- or post-orthognathic surgery/orthodontic treatment approach.

24. **Non-Participating Dentist.** A Dentist who has not signed a Participating Agreement with Delta Dental Plan of Maine or any other Delta Dental company.

25. **Office Visit Co-pay (OVCP).** With a few exceptions, each time you, or a person covered under this plan, visits a Dentist or Other Dental Provider to receive services covered under this plan, you must pay to the provider an Office Visit Co-pay of $30. The OVCP will be applied after any Deductible and Coinsurance Percentage.

26. **Other Dental Providers (ODP)**. A person, other than a Dentist, who provides Dental Care and is licensed to provide such services by the state in which the services are provided.

27. **Participating Dentist.** A Dentist who has signed a Participating Agreement with Delta Dental Plan of Maine or any other Delta Dental company.

28. **Pediatric Enrollee.** Any person enrolled in the plan under the age of nineteen (19) as of the effective date of the plan.

29. **Plan Year.** The time period starting with enrollment through the end of the calendar year.

30. **Predetermination.** A process by which the Dentist sends a treatment plan to Delta Dental before providing Dental Care. Delta Dental recommends that you ask your Dentist to request a Predetermination of proposed services that are considered to be other than brief or routine. A Predetermination provides an estimate of what Delta Dental will pay for the services which helps avoid confusion and misunderstanding between you and your Dentist.

31. **Prior Authorization.** A required process by which the Dentist sends a treatment plan to Delta Dental before performing certain procedures for approval based upon Delta Dental's review. There is no prior authorization required for emergency services.

32. **Processing Policies.** Policies approved by Delta Dental, as may be changed from time to time. Processing Policies are used to process claims for payment or review, and to process treatment plans for Prior Authorization or Predetermination. The Processing Policies used most often can be found in the terms, conditions, exclusions, and limitations in this DPD.

33. **Subscriber.** The Contract Holder if he or she enrolls in the dental plan.

III. Information About Your Plan.

The Way Your Plan Works.

1. Covered Services. Section V of this DPD gives the details of the dental benefits covered by this plan. A summary of the coverages follows.

   (a) Diagnostic and Preventive Services. This plan will pay 100% of the allowed charge. There is no Deductible for these services.

   (b) Basic Restorative Services. This plan will pay 60% of the allowed charge once the Plan Year Deductible has been met.

   (c) Major Restorative Services. This plan will pay 50% of the allowed charge once the Plan Year Deductible has been met.

   (d) Medically Necessary Orthodontic Services. This plan will pay 50% of the allowed charge. There is no Deductible for these services. This coverage is for Pediatric Enrollees only.

2. Plan Year Deductible. This plan includes a Deductible of $150 per Enrollee per Plan Year. The Deductible is only applied to Basic and Major Restorative Services. The Deductible does not apply to Medically Necessary Orthodontic services, which are only available to Pediatric Enrollees. Expenses for non-covered services are not applied toward the Deductible.

3. Annual Maximum. This plan has an annual Maximum for each Adult Enrollee in the amount of $1,000 per Plan Year. The Annual Maximum does not apply to Pediatric Enrollees.

4. Maximum Out-of-Pocket (MOOP). The plan includes an annual MOOP that limits the amount you are required to pay for covered services for Pediatric Enrollees. The annual MOOP is $350 for each Pediatric Enrollee per Plan Year up to a maximum of $700 for all Pediatric Enrollees in one family covered by this plan per Plan Year. Payments you make to providers who are not Delta Dental PPO Dentists, and any expenses you pay for non-covered services do not count toward the MOOP. The annual MOOP does not apply to Adult Enrollees.

Summary of Benefits follows.

Summary of Benefits. The summary of benefits provides a brief description of the important features of your policy. This policy sets forth in detail the rights and obligations of both you and Delta Dental. The policy provisions will control. It is important that you READ YOUR POLICY CAREFULLY!

The table below summarizes the way your plan works for Pediatric Enrollees and Adult Enrollees. Please refer to Sections V and VI of this policy for details regarding the benefits, exclusions, limitations, and waiting periods.

Delta Dental Family – Low Plan.			
Benefits/Features.	Pediatric Enrollees (under age 19).		Adult Enrollees (Over age 19).
	Benefits prior to reaching the Maximum Out-of-Pocket.	Benefits after reaching the Maximum Out-of-Pocket.	
Plan Year Maximum Out-of-Pocket.[1]	$350	N/A	None
Diagnostic & Preventive (Coverage A).[2]	100%	100%	100%
Basic Restorative (Coverage B).[2] (Deductible applies).	60%	100%	60%[3]
Major Restorative (Coverage C).[2] (Deductible applies).	50%	100%	50% [4]
Medically Necessary Orthodontia (Coverage D).[2]	50%[5]	100%	N/A
Plan Year Deductible Per Person (Applies to Basic and Major coverages only).	$150	$0	$150
Office Visit Co-pay (Applies to Diagnostic & Preventive, Basic, and Major coverages only).	$30	None	$30
Plan Year Maximum Per Person.	None	None	$1,000

[1]Only out-of-pocket expenses incurred by enrollees under the age of 19 for covered services received from Delta Dental PPO Dentists are counted toward the Plan Year Maximum Out-of-Pocket. MOOP capped at $700 per family. Enrollees will keep the Under Age 19 benefits through the end of the Plan Year in which they turn 19. [2]Delta Dental's liability is based upon the Coinsurance Percentage of the "allowed charge" as described in this policy. [3]After a 3-month waiting period. [4]After a 6-month waiting period. [5]After a 24-month waiting period.

A. What Your Plan Pays.

Your dental plan's payment is based on the "allowed charge" for a covered service. The allowed charge is determined by whether the provider of the services is a Delta Dental PPO Dentist, a Delta Dental Premier Dentist, or does not participate with Delta Dental.

1. If the Dentist is a Delta Dental PPO Dentist, the allowed charge will be the lesser of the submitted charge or Delta Dental's allowance for PPO Dentists in the area in which the services were provided. Your responsibility will be any Deductible, Co-Payment and Coinsurance. The Dentist cannot receive in total more than Delta Dental's allowance for PPO Dentists.

2. If the Dentist is a Delta Dental Premier Dentist, the allowed charge will be the lesser of the submitted charge or Delta Dental's allowance for PPO Dentists in the area in which the services were provided. Your responsibility will be any Deductible, Co-Payment, and Coinsurance, and any difference between your plan's payment and Delta Dental's allowance for Premier Dentists in the area in which the services were provided. The Premier Dentist cannot receive more than the allowance for Premier Dentists and has agreed not to bill you for more than that amount.

3. If the Dentist is a Non-Participating Dentist or Other Dental Provider, the allowed charge will be the lesser of the submitted charge or Delta Dental's allowance for Non-Participating Dentists or ODPs in the area in which the services were provided. Your responsibility will be any Deductible, Co-Payment, and Coinsurance, and any difference between your plan's payment and the provider's charge for this service. It is in your best interest to discuss what the charge will be before receiving the service.

B. Paying Your Premiums.

This policy is being offered on the federally facilitated Health Insurance Marketplace operated by HHS (the "FFM"). You may choose to pay the required monthly premiums by automatic credit card or debit card charges, or by direct, automated payments from your bank account (Electronic Funds Transfer or EFT) by establishing an account with Delta Dental or its third party service provider. If you choose to pay by personal check, Delta Dental, directly or through a third party service provider, will bill and collect the required premiums.

Unless you are a recipient of advance payments of premium tax credits from which premiums are paid to Delta Dental in part, you have a thirty-one (31) day premium grace period for any monthly premium payment you must make. If you do not pay your premium in full by the end of your grace period, your coverage will end on the last day of the grace period.

If you are the recipient of advance premium tax credits from which premiums are paid to Delta Dental in part, you have a three (3) month premium grace period for any monthly premium you must make. If you pay your required premium payment in full before the end of the grace period, your coverage will not be affected. If you do not pay your premium in full by the end of your grace period, your coverage will end retroactive to the end of the first thirty-one (31) day grace period.

C. Eligibility and Enrollment.

1. HHS and the FFM policies and procedures govern eligibility and enrollment in this dental plan, including open and special enrollment periods. Such policies and procedures shall supersede any conflicting provisions hereof.

2. Effective Date of Eligibility:

   (a) Initial Effective Date. Subject to the terms and conditions hereof and FFM policies and procedures, coverage under this plan will commence on the date determined by the FFM. Delta Dental will notify Contract Holder of such effective date.

   (b) After the initial Effective Date. For all Dependents (if any) not eligible for benefits as of the Effective Date, eligibility for benefits will commence on the date determined by the FFM and as notified by Delta Dental. All eligible Dependents (if any) shall be eligible

for benefits in accordance with FFM policies and procedures governing qualifying events for special enrollment.

Any person meeting the requirements of a "Dependent" as defined in Section II of this Certificate of Insurance may be enrolled for coverage under this dental plan, subject to the enrollment and termination provisions hereof, the requirements of the FFM, and applicable law.

3. The Contract Holder may add an eligible Dependent.

   (a) During an annual open enrollment period of at least thirty (30) days prior to the end of the current Plan Year as established by the FFM.

   (b) Within sixty (60) days of the occurrence of a qualifying event such as marriage, divorce, birth, or adoption.

   (c) Within sixty (60) days of the occurrence of a "qualifying event" which triggers a special enrollment period under FFM policies and procedures.

   Dependents added after a qualifying event will have coverage effective on the date determined by the FFM, and Delta Dental will notify the Dependent of the effective date of coverage.

D. Termination of Your Plan.

1. Termination by you. When you buy this policy, you commit to keep it for the Plan Year. However, you may qualify to terminate this policy earlier than the end of the Plan Year, but only for one of the following reasons.

   (a) The Enrollee becomes covered under a group dental policy or obtains minimum essential coverage.

   (b) If an Enrollee dies, the person's coverage will terminate after you or your personal representative provide notice to Delta Dental.

   If you want to terminate your policy for either of these events, you must notify us and the FFM in writing at least fourteen (14) days in advance of the requested effective date of termination of coverage for the Enrollee. If you provide the fourteen (14) day notice, coverage will terminate for the Enrollee on the date you request. If you do not specify an effective date, the policy will terminate fourteen (14) days after you request termination, or an earlier date if you request earlier termination and Delta Dental can effectuate termination in fewer than fourteen (14) days.

   If any Enrollee dies, you or your personal representative shall promptly notify us and the FFM in writing and the effective date of termination of coverage shall be the date of death.

   If you cancel your policy, Delta Dental or its third party service provider shall return any unearned portion of the premium within thirty (30) days. The earned premium shall be computed on a pro-rata basis.

   Notice of termination of this policy should be submitted to the FFM.

2. Termination by Delta Dental. By required written notice delivered to you at the address last shown in our records, Delta Dental may terminate your policy before the end of the Plan Year for any of the following reasons.

   (a) You do not pay the policy premiums when due, including grace periods, in accordance with FFM requirements.

   (b) You or the Enrollee commits, or attempts to commit, fraud or material misrepresentation having to do with this policy and coverage is rescinded pursuant to applicable law.

   (c) This plan terminates or is decertified by HHS or the Maine Bureau.

   (d) The Enrollee changes from this policy to another plan that includes minimum essential coverage.

Delta Dental may also terminate coverage for an Enrollee under your policy if we become aware that the Enrollee is no longer eligible for coverage under this policy in accordance with HHS policies and procedures.

In the event of termination by Delta Dental, Delta Dental or its third party service provider will return the unearned portion of any policy premium within thirty (30) days. The earned premium shall be determined on a pro-rata basis.

3. Effective Date of Termination. Except as specifically referenced in this Section D., coverage and benefits under this policy will terminate for the Enrollees on the date this policy terminates. The effective date of termination will be:

   (a) The last day of the month following receipt by the Contract Holder of required notice and the expiration of the grace period in the event premiums are not paid when due.

   (b) The last day of your current Plan Year if you change your legal residence to a place other than Maine.

   (c) Following receipt of thirty (30) days written notice of termination due to fraud or material misrepresentation.

   (d) The last day of your current Plan Year in which this plan terminates or is decertified.

   (e) The effective date of the replacement coverage through another plan including minimum essential coverage.

E. Renewal and Non-Renewal.

This policy is subject to the renewal requirements of the FFM. If renewed, the policy will continue for a new twelve (12) month Plan Year if the premium continues to be paid by the Contract Holder. If you do not want the policy to be renewed, send written notice to Delta Dental before the policy's renewal date. If you send notice not to renew, this policy will terminate on the last day of the current Plan Year. If we send you notice of non-renewal at least ninety (90) days before the end of the Plan Year, your policy will end on the last day of the Plan Year.

Prior to renewal, Delta Dental will give at least sixty (60) days written notice of any premium adjustment. If the Contract Holder sends written notice to the federally-facilitated Health Insurance Marketplace before the renewal date, your policy will end as of the last day of the Plan Year.

If you, Delta Dental or HHS provide written notice that your policy will not be renewed, your policy will end on the last day of the Plan Year.

If any renewal premium is not paid within the time granted for payment, your policy will be reinstated if HHS, Delta Dental, or a duly authorized agent accepts a premium payment without requiring an application for reinstatement. If HHS, Delta Dental or such agent requires an application for reinstatement and issues a conditional receipt for the premium paid, the policy will be reinstated upon approval of such application by HHS or Delta Dental. The policy will be reinstated upon the 45th day following the date of such conditional receipt unless HHS or Delta Dental has previously notified you in writing of its disapproval of your application.

A policy that has been reinstated shall only cover claims after the date of reinstatement. In all other respects you, Delta Dental and HHS shall have the same rights as each had under the policy immediately before the due date of the defaulted premium. Any premium accepted with reinstatement shall be applied to the outstanding balance dating back no more than sixty (60) days prior to the date of reinstatement.

F. Reporting a Change in Status for a Person Covered Under Your Plan.

You must notify Delta Dental at 1-800-832-5700and the FFM at toll free 1-800-318-2596 (TTY 1-855-899-4325) of any event that causes a change in your status or that of an Enrollee covered under your plan. Events that can affect status include marriage, birth, adoption, death, divorce, an Enrollee reaching nineteen (19) years of age, a Dependent child reaching twenty-six (26) years of age, or a change of address.

IV. How to File a Claim.

To Use Your Plan, Follow These Steps.

This Dental Plan Description describes the benefits and provisions of your dental plan. Please read it carefully.

The coverage selected for your plan uses Delta Dental's PPO network of Participating Dentists. You get the best value when you obtain care from a Delta Dental PPO Dentist. Delta Dental PPO Dentists in your area can be found by accessing our provider directory located on our website ***www.nedelta.com*** under "Find a Dentist." In the event that you are not able to obtain services from a Delta Dental PPO Dentist in your area, please promptly contact our Customer Service at 1-800-832-5700 or 603-223-1234 to seek assistance in finding a Delta Dental PPO Dentist. If you contact us regarding the lack of access to a PPO Dentist, we will work with you to provide reasonable access to a PPO Dentist near your home or work (within 40 miles). We will continue to recruit PPO Dentists in your area. If we are unable to find you a PPO Dentist near your home or work in a reasonable period of time, we will direct you to another Dentist. You will be covered as if you were treated by a PPO Dentist in accordance with the terms and conditions of your plan.

When you visit your dental office, inform them that you are covered under a Delta Dental program. Provide your identification card or other means of verifying Delta Dental coverage. Your Dentist will perform an evaluation and plan the course of treatment. When the treatment has been completed, the claim form will be sent to Delta Dental for payment for covered services. Clean written claims must be paid in 30 days; clean electronic claims must be paid within 15 days.

Participating Dentists. Participating Dentists will have claim forms available in their offices. A Participating Dentist will not charge at the time of treatment for covered services, but may request payment for non-covered services, and Deductibles, Co-Payments and Coinsurance. Delta Dental will pay the Participating Dentists directly based on the allowed charge. An Explanation of Benefits will be available to you which will indicate the amount you should pay, if any, to your Dentist.

Non-Participating Dentists or Other Dental Providers. Delta Dental provides coverage regardless of your choice of Dentist. When visiting a Non-Participating Dentist or ODP, you may be required to submit your own claim (available at ***www.nedelta.com***) and pay for services at the time they are provided. All claims should be submitted to Delta Dental. Payment will be made directly to you. Some states may require that assignment of benefits be honored. In these instances, payment will be made directly to the Non-Participating Dentist or ODP when written notice of an assignment is made on the claim. In either case, payment for treatment by a Non-Participating Dentist or ODP will be limited to the lesser of the submitted charge or Delta Dental's allowance for Non-Participating Dentists or ODPs in the area in which services were provided. It is your responsibility to make full payment to the Dentist or ODP. When there is not enough fee information available, Delta Dental will determine an appropriate payment amount.

You or someone in the dental office must fill in the patient information portion of the claim form. Please be sure information is complete and accurate to ensure the prompt and correct payment of your claim.

International Dentists (Non-Participating): Delta Dental provides coverage for international services and supplies in an amount equal to the covered percentage for the charges incurred by you and subject to Deductibles, Co-Payments, and Coinsurance outlined in this plan. All payments will be made in US currency. Your responsibility is to pay the Dentist is full, obtain a claim form with appropriate ADA approved CDT codes from the Dentist and submit the claim to Delta Dental for reimbursement. Completed claim forms can be mailed to:

Northeast Delta Dental
PO Box 2002
Concord, NH 03302-2002

Prior Authorizations. For several identified procedures, Prior Authorization is required for Pediatric Enrollees.

Please note that Prior Authorization does NOT guarantee payment. A new Coverage Period, additional paid benefits and/or a contract change may alter the final payment, because payment is based on information on file at the time treatment is provided (the date of service) which may be different than information available at the time of the Prior Authorization. Any changes in a Dentist's participating status or Delta Dental's allowance may also affect Delta Dental's final payment.

Predetermination of Benefits. Delta Dental encourages Predetermination of cases involving costly or extensive treatment plans. Although not required, Predetermination helps avoid confusion regarding Delta Dental's payment and your financial obligation to the Dentist. A Predetermination voucher reflects your benefits based on the procedures and costs submitted by your dental office.

Please note that Predetermination does NOT guarantee payment. Rather, Predetermination is an estimate of payment based on your current benefits. A new Coverage Period, additional paid benefits and/or a contract change may alter the final payment, because payment is based on information at the time treatment is provided (the date of service) which may be different than information available at the time of the Predetermination estimate. Any change in a Dentist's participating status or Delta Dental's allowance may also affect Delta Dental's final payment.

Questions concerning Prior Authorization and Predetermination should be directed to Delta Dental's Customer Service at 1-800-832-5700 or 603-223-1234.

V. Benefits.

In this section of your policy, we give you the details of what services your policy covers and the conditions and limitations on those services. **This section includes significant dental terminology adopted by the American Dental Association. We encourage you to discuss proposed services and treatment plans with your Dentist/dental office.** In addition, should you have any questions regarding those services, you may call Customer Service at 1-800-832-5700 Monday through Friday from 8:00 a.m. to 4:45 p.m. EST excluding holidays.

Diagnostic & Preventive Benefits (Coverage A).

Diagnostic. Oral evaluations are covered one time in a period of six (6) months. Evaluations can be comprehensive, limited or periodic and may be provided by a specialist or a general Dentist.

Radiographic images are covered with limitations. Complete series or panoramic image are covered once in a period of five (5) years. Bitewings are covered once in a period of twelve (12) months. Images of individual teeth are covered as necessary.

Caries risk assessment is covered one time in a period of three (3) years for children between the ages of three (3) and nineteen (19).

Preventive. Prophylaxis (cleaning) is covered one time in a period of six (6) months. A child cleaning is through age thirteen (13); an adult cleaning is thereafter). A cleaning can be routine under Diagnostic and Preventive Benefits or a periodontal maintenance under Basic Restorative Benefits.

A full mouth debridement is a covered benefit, once in a lifetime, under Diagnostic & Preventive Benefits. When performed, it is counted towards your cleaning benefit.

Fluoride treatments are covered two (2) times in a period of twelve (12) months for Pediatric Enrollees only.

Sealants are a covered benefit for Pediatric Enrollees only.

Space maintainers are a covered benefit for Pediatric Enrollees only.

Palliative Treatment. Minor emergency treatment for the relief of pain.

NOTE: Time limitations are measured from the date the services were most recently performed.

All covered services for Pediatric Enrollees with an age or frequency limitation are available for age exception or more frequent treatment with Prior Authorization.

Diagnostic & Preventive Benefits - Exclusions and Limitations.

- If the fee for a procedure or service is **"Disallowed"**, it is not payable by Delta Dental, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is **"Denied"**, it is not payable by Delta Dental, but is chargeable to the patient as the procedure or service is not a benefit of the patient' plan.

1. Charges for oral evaluations of any kind are Disallowed, if performed within ninety (90) days after periodontal surgery, by the same Dentist/dental office.
2. Charges for oral evaluations for patients under age three (3) are Disallowed when performed on the same date of service by the same Dentist/dental office as a comprehensive evaluation.
3. Pre-diagnostic services, such as screening and assessment of a patient, are not covered benefits. Payment for a screening or assessment is Disallowed if billed with an oral evaluation.
4. A panoramic radiographic image, with or without supplemental radiographic images (such as periapicals, bitewings and/or occlusal), is considered a complete series for time limitations. Any fee in excess of the fee for a complete series is Disallowed.

5. Unless there is evidence of trauma, charges for additional periapical radiographic images within a thirty (30) day period of a complete series or panoramic image is Disallowed.

6. When benefits are requested for a panoramic radiographic image in conjunction with a complete series by the same Dentist/dental office, fees for the panoramic radiographic image are Disallowed as a component of the complete series on the same date of service.

7. Routine working and final treatment radiographic images taken for endodontic therapy by the same Dentist/dental office are considered a component of the complete treatment procedure. Separate fees are Disallowed on the same date of service.

8. If the fee for bitewings, periapicals, intraoral occlusal and extraoral occlusal radiographic images is equal to or exceeds the fee for a full mouth series, it is considered a full mouth series for payment purposes and time limitations. Any fee in excess of the fee for the full mouth series is Disallowed on the same date of service.

9. Cone beam imaging and interpretation are not covered benefits. Cone beam imaging, when performed by the same Dentist/dental office as an image interpretation, is combined as a cone beam capture and interpretation. Any fees in excess of the combined codes are Disallowed.

10. Cephalometric images, oral/facial photographic images, and diagnostic models are covered once every two (2) years when performed for potential Medically Necessary Orthodontic treatment only.

11. Oral cancer screening, except brush biopsy, is not a covered benefit.

12. Oral Pathology laboratory services are a covered benefit when accompanied by a pathology report. If more than one of these procedures is billed for the same tooth site on the same day, by the same Dentist/dental office, payment is allowed for the most inclusive procedure and payment for the less inclusive procedure is Disallowed.

13. A cleaning done on the same date by the same Dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures. The fee is Disallowed.

14. Cleanings (a Diagnostic & Preventive benefit) are included in both full mouth debridement (a Diagnostic & Preventive benefit) and periodontal maintenance (a Basic Restorative benefit). As a result, each of these procedures is counted toward your cleaning benefit of once in a six (6) month period.

15. Laboratory tests for caries susceptibility are not a covered benefit. Fees are Disallowed when billed with an oral evaluation for children under the age of three (3).

16. Caries risk assessment is a covered benefit once in a period of three (3) years for children between the ages of three (3) and nineteen (19). Fees for caries risk assessment are Disallowed if billed for children under the age of three (3), if billed within twelve (12) months by the same Dentist/dental office, or if performed with other risk assessments by the same Dentist/dental office.

17. The replacement of space maintainers is not a covered benefit. The patient is financially responsible.

18. The repair of space maintainers is not a covered benefit. The patient is financially responsible.

19. Recementation of a space maintainer is a covered benefit once in a lifetime per appliance.

20. Removal of a space maintainer is included as part of the total treatment. Charges for removal of a space maintainer are Disallowed if performed by the same Dentist/dental office as the initial placement or if performed with the recementation of a space maintainer.

21. Sealant benefit limitation.

    (a) The sealant benefit is a covered benefit for Pediatric Enrollees only.

    (b) The sealant benefit is for the application of sealants to caries-free and restoration-free, occlusal (biting) surface of permanent molars only.

    (c) The sealant benefit is provided no more than once in a three (3) year period per tooth.

(d) Charges for sealants are Disallowed within two (2) years of initial placement on the same tooth by the same Dentist/dental office. Charges for a sealant are Disallowed if performed on the same tooth, by the same Dentist/dental office, on the same date of service as a restoration which includes the occlusal surface.

22. Preventive resin restorations are a covered benefit one (1) time per tooth in a period of three (3) years on permanent molars for Pediatric Enrollees only. Fees are Disallowed if replaced by the same Dentist/dental office within twenty-four (24) months. Fees for a preventive resin restoration is Disallowed if performed on the same tooth, by the same Dentist/dental office on the same date of service as another restoration.

23. The fee for preventive resin restoration is Disallowed if performed on the same date of service as a conventional restoration or palliative treatment by same Dentist/dental office.

24. Pulp vitality tests are a covered benefit only when done in conjunction with a radiographic image, a limited oral evaluation, a palliative treatment or a protective restoration. Payment is otherwise Disallowed.

25. Palliative treatment is a covered benefit. The third palliative treatment claim received in 180 days is subject to a dental consultant's review.

26. Palliative treatment is part of the initiation of endodontic therapy and therefore is included in the fee when performed on the same date by the same Dentist/dental office and a separate fee is Disallowed.

27. The fee for palliative treatment is Disallowed when submitted with all procedures performed by the same Dentist/dental office on the same date, except radiographic images and diagnostic codes.

28. Viral culture tests, saliva tests, and oral cancer screening are not covered benefits. The patient is financially responsible.

29. Nutritional counseling, tobacco counseling, and oral hygiene instruction are not covered benefits. The patient is financially responsible.

30. TMJ related services are not covered benefits. The patient is financially responsible.

Basic Restorative Benefits (Coverage B).

Restorative.	Amalgam (silver) restorations (fillings) are a covered benefit.
	Resin (white) restorations (fillings) on anterior (front) teeth are a covered benefit.
	Prefabricated stainless steel crowns are a covered benefit.
	Recementation of an inlay or crown is a covered benefit.
	Protective restorations are a covered benefit.
Periodontal Maintenance.	A periodontal maintenance procedure is a covered benefit after active periodontal therapy four (4) times in a twelve (12) month period and when performed, is counted toward the prophylaxis benefit.
Periodontics.	Periodontal scaling and root planing is a covered benefit once in a period of twenty-four (24) months.
Endodontics.	Pulpotomy and pulpal therapy are covered benefits.
Oral Surgery.	Extractions and certain surgical procedures are covered benefits.
Prosthodontic Services.	Denture repair, adjustment, rebase and reline are covered benefits.
Tissue conditioning.	Two (2) times in a three (3) year period.

Anesthesia (Adult Enrollees only). General anesthesia or intravenous sedation is a covered benefit when administered in a dental office and in conjunction with: an extraction; a tooth reimplantation; surgical exposure of a tooth; surgical placement of an implant body; a transseptal fiberotomy; an alveoloplasty; an incision and drainage of an abscess; a frenulectomy and/or a frenuloplasty.

Anesthesia (Pediatric Enrollees only). General anesthesia or intravenous sedation are covered benefits when done in conjunction with other covered services.

Note: ***Time limitations are measured from the date the services were most recently performed.***

All covered services for Pediatric Enrollees with an age or frequency limitation are available for age exception or more frequent treatment only with Prior Authorization.

Basic Restorative Benefits - Exclusions and Limitations.

- If the fee for a procedure or service is **"Disallowed"**, it is not payable by Delta Dental, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is **"Denied"**, it is not payable by Delta Dental, but is chargeable to the patient as the procedure or service is not a benefit of the patient' plan.

1. Resin (white) or amalgam (silver) restorations (fillings) are a covered benefit once per tooth surface in a period of twenty-four (24) months, irrespective of the number or combination of procedures performed. Charges for the replacement of silver or white fillings within twenty-four (24) months by the same Dentist/dental office are Disallowed.
2. Resin restorations (white fillings) in bicuspids and molars are optional. A payment will be made equal to a silver filling. If a white filling is done, the patient is responsible for any additional fee.
3. Resin based composite crowns on front teeth are a covered benefit once in a period of two (2) years per tooth for patients age twelve (12) and older. Fees are Disallowed if replaced within two (2) years by the same Dentist/dental office.
4. An adjustment will be made for two (2) or more restoration surfaces which are normally joined together. A Participating Dentist agrees not to charge a separate fee.
5. Prefabricated stainless steel crowns are a covered benefit once in a period of twenty-four (24) months. The fee for replacement of a stainless steel crown by the same Dentist/dental office within twenty-four (24) months is included in the initial crown placement. A separate fee is Disallowed.

6. Recementation of a metallic inlay or onlay, or a crown or partial coverage restoration is a covered benefit once in a lifetime. Payment for recementation of an inlay, onlay, crown or partial coverage restoration is Disallowed when performed within six (6) months of the initial placement by the same Dentist/dental office.
7. Payment is made for one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed. A Participating Dentist agrees not to charge a separate fee.
8. Fees for protective restorations are Disallowed if performed on the same date of service as a palliative treatment by the same Dentist/dental office.
9. A Routine cleaning is included in a full mouth debridement and a periodontal maintenance cleaning. As a result, each of these procedures is counted toward your cleaning benefit of once in a six (6) month period.
10. A cleaning done on the same date by the same Dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures. The fee is Disallowed.
11. Fees for periodontal maintenance are Disallowed when billed within three (3) months of periodontal therapy by the same Dentist/dental office.
12. Periodontal scaling and root planing is a covered benefit per quadrant once in a period of twenty-four (24) months. Benefits are paid for a maximum of two (2) quadrants per office visit. Fees are Disallowed for twenty-four (24) months after the initial therapy if the retreatment is performed by the same Dentist/dental office. If treatment is done by a different Dentist within twenty-four (24) months, benefits are Denied. The patient is responsible for the fee.
13. A partial pulpotomy is a covered benefit, once per tooth per lifetime, on permanent teeth only. The fee for a partial pulpotomy is Disallowed if performed within forty-five (45) days on the same tooth by the same Dentist/dental office as root canal therapy.
14. Pulpal therapy or therapeutic pulpotomy is a covered benefit once in a three (3) year period per tooth on primary teeth only. If provided on permanent teeth, the benefit is Denied. The fee for pulpal therapy or therapeutic pulpotomy is Disallowed if performed within forty-five (45) days of a root canal treatment by the same Dentist/dental office.
15. Pulpal debridement is a covered benefit once in a lifetime. The fee for pulpal debridement is Disallowed if performed within thirty (30) days of a root canal treatment by the same Dentist/dental office.
16. Routine post-operative visits are considered part of, and included in the fee for, the total procedure. A Participating Dentist agrees not to charge a separate fee.
17. Pin retention is a covered benefit once per tooth in a period of twenty-four (24) months in conjunction with all restorations. Fees for additional pins in the same tooth are Disallowed. The fee for pin retention is Disallowed when billed in conjunction with a core build-up.
18. Post-operative treatment of complications from oral surgery is a covered benefit once per surgical site, subject to a dental consultant's review. The fee for post-operative treatment of complications is Disallowed if performed within thirty (30) days by the same Dentist/dental office as the oral surgery.
19. The fee for surgical removal of residual tooth roots is Disallowed when performed on the same date of service as an extraction by the same Dentist/dental office.
20. Alveoplasty is included in the fee for surgical extractions. Separate fees for these procedures are Disallowed if performed by the same Dentist/dental office in the same surgical area on the same date.
21. A frenulectomy or frenuloplasty is a covered benefit once per site per lifetime. The fee is Disallowed when billed on the same date as any other surgical procedure in the same surgical area by the same Dentist/dental office.
22. Reattachment of a tooth fragment, including the incisal edge or cusp, is a covered benefit. Payment is Disallowed if performed within twenty-four (24) months of a restoration on the same tooth by the same Dentist/dental office.
23. A consultation performed by a practitioner who is not performing further services is a covered benefit. The fee for a consultation is Disallowed if performed in conjunction with an oral evaluation by the same Dentist/dental office on the same date of service.

24. Exploratory surgical services are not a covered benefit. The patient is financially responsible.

25. General anesthesia is a benefit only when administered by a properly licensed Dentist in a dental office with covered oral surgical procedures or when necessary due to concurrent medical conditions. Otherwise, the fee for general anesthesia is Denied.

26. The fee for repair of a complete denture cannot exceed half the fee for a new appliance. Any excess fee billed by the same Dentist/dental office on the same date of service is Disallowed.

27. Fees for repairs of complete or partial dentures, if performed within six (6) months of initial placement by the same Dentist/dental office are Disallowed.

28. Adjustment or repair of a denture is a covered benefit twice in a twelve (12) month period. Fees for an adjustment or repair of a denture is Disallowed if performed within six (6) months of initial placement. The fee for an adjustment or repair of a denture cannot exceed one-half of the fee for a new appliance. Any excess fee by the same Dentist/dental office on the same date of service is Disallowed.

29. The relining of a denture is a covered benefit two (2) times in a period of twelve (12) months. The fee for reline of a denture cannot exceed one-half of the fees for a new appliance. Any excess fee by the Dentist/dental office is Disallowed.

30. The rebase of a denture is a covered benefit once in three (3) years. The fee for rebase of a denture cannot exceed one-half of the fee for a new appliance. Any excess fee by the same Dentist/dental office is Disallowed.

31. The fee for a reline or rebase of a denture is Disallowed if performed within six (6) months of initial placement by the same Dentist/dental office.

32. Rebase and reline include adjustments required within six (6) months of delivery. When an adjustment is billed within six (6) months of a rebase or reline by the same Dentist/dental office, fees for the adjustment are Disallowed.

33. Recementation of a fixed partial denture is a covered benefit once in a period of twelve (12) months. Fees for recementation of fixed partial dentures are Disallowed if done within six (6) months of the initial placement by the same Dentist/dental office.

34. Recementation of a prefabricated post and core is a covered benefit once per tooth per lifetime. Payment is Disallowed if performed within six (6) months of the initial placement by the same Dentist/dental office, or if performed on the same date of service of a crown recementation by the same Dentist/dental office.

35. Tissue conditioning is a covered benefit two (2) times in a three (3) year period. The fee for tissue conditioning is not a benefit if performed on the same day the denture is delivered or a reline/rebase is provided by the same Dentist/dental office and is Disallowed

36. Tooth preparation, bases, copings, protective restorations, impressions, and local anesthesia, or other services that are part of the complete dental procedure, are considered components of, and included in the fee for, a complete procedure. Separate fees are Disallowed.

37. Therapeutic drug injections are a covered benefit subject to a dental consultant's review.

38. Local anesthesia in conjunction with any procedure by the same Dentist/dental office is considered part of the overall procedure. Separate fees are Disallowed.

39. Excision of lesions is not a covered benefit. The patient is financially responsible.

Please note: ***Certain procedures for Pediatric Enrollees as expressly identified require Prior Authorization from Delta Dental. Separate from any required Prior Authorization, Delta Dental encourages Predetermination of cases involving costly or extensive treatment plans. Although not required, Predetermination helps avoid confusion regarding Delta Dental's payment and your financial obligation to the Dentist.***

Major Restorative Benefits (Coverage C).

Restorative Crowns and Onlays.	Crowns and metallic inlays and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations.
	Core build-ups, prefabricated post and cores and crown repair for enrollees age twelve (12) and older.
Endodontics.	Root canal therapy, apicoectomy, apexification, root amputation, and hemisection.
Periodontics.	Gingivectomy, gingivoplasty, gingival flap procedure, clinical crown lengthening, osseous surgery, and soft tissue graft.
Prosthodontics.	Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures.
Implant Services.	Surgical placement of an implant body, including healing cap, for enrollees age sixteen (16) and older.
Implant Supported Prostheses.	Crowns, fixed or removable partial dentures, and full dentures anchored in place by an implanted device for enrollees age sixteen (16) and older.
Occlusal Guard.	Once in a twelve (12) month period for patients age thirteen (13) and older.

Note: ***Time limitations are measured from the date the services were most recently performed.***

All covered services for Pediatric Enrollees with an age or frequency limitation are available for age exception or more frequent treatment only with Prior Authorization.

Major Restorative Benefits - Exclusions and Limitations.

- If the fee for a procedure or service is **"Disallowed"**, it is not payable by Delta Dental, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is **"Denied"**, it is not payable by Delta Dental, but is chargeable to the patient as the procedure or service is not a benefit of the patient' plan.

1. Inlays and onlays (metallic) and crowns made of resin-based composite, porcelain, porcelain fused to metal, full cast metal, or resin fused to metal, where the metal is high noble metal, titanium, noble metal or predominantly base metal, are not benefits for Enrollees under the age of twelve (12) without a Prior Authorization.
2. Time limitations.
   (a) One (1) complete maxillary (upper) and one (1) complete mandibular (lower) denture in a period of five (5) years.
   (b) One (1) immediate maxillary (upper) and one (1) immediate mandibular (lower) denture in a period of five (5) years.
   (c) A removable or fixed partial denture in a period of five (5) years unless the loss of additional teeth requires the construction of a new appliance.
   (d) Metallic onlays, crowns, core build-ups, and post and cores are a benefit once per tooth in a period of five (5) years.
3. A core build-up is a covered benefit once in a five (5) year period per tooth for patients age twelve (12) and older. The fees for core build-ups are Disallowed when performed in conjunction with inlays, ¾ crowns or onlays.
4. A provisional crown is considered part of a crown procedure when performed by the same Dentist/dental office as a permanent crown. A separate fee is Disallowed.

5. An indirectly fabricated and prefabricated post and core in addition to a crown is payable only on an endodontically treated tooth and is a covered benefit once in a five (5) year period for patients age twelve (12) and older. Fees for post and cores are Disallowed when radiographic images indicate an absence of endodontic treatment, incompletely filled canal space, or unresolved pathology associated with the involved tooth. Each additional post in the same tooth is considered part of the post and core procedure. A separate fee is Disallowed.

6. Root canal therapy is a covered benefit once per tooth in a period of twenty-four (24) months. Retreatment of root canal therapy or retreatment of apical surgery by the same Dentist/dental office within twenty-four (24) months is considered part of the original procedure. Fees for the retreatment by the same Dentist/dental office are Disallowed.

7. Anterior deciduous root canal therapy is not a covered benefit.

8. Root canal therapy is not a benefit in conjunction with overdentures. Benefits are Denied.

9. Post removal is Disallowed if performed within thirty (30) days of an endodontic treatment by the same Dentist/dental office performing the endodontic retreatment.

10. Direct or indirect pulp caps are a covered benefit once per tooth in a period of three (3) years. A pulp cap performed on the same date of service as the final restoration by the same Dentist/dental office is considered part of a single complete restorative procedure. The fee for the pulp cap is Disallowed.

11. The fee is Disallowed for root amputation performed in conjunction with an apicoectomy by the same Dentist/dental office.

12. Periodontal surgical procedures include all necessary post-operative care, finishing procedures, and evaluations for three (3) months, as well as any surgical re-entry (except soft tissue grafts), for three (3) years. When a surgical procedure is billed within three (3) months of the initial surgical procedure by the same Dentist/dental office, the fee for the surgery is Disallowed.

13. Gingivectomy, gingivoplasty, gingival flap procedure, osseous surgery, or soft tissue graft procedure are benefits once in a period of three (3) years. The charge for surgical re-entry by the same Dentist/dental office within three (3) years is Disallowed.

14. An apexification or an apicoectomy is a covered benefit once per tooth in a period of three (3) years. The fee for retreatment by the same Dentist/dental office within twenty-four (24) months is Disallowed.

15. An internal root repair is not a covered benefit. If performed on a primary tooth the benefit is denied. The fee for an internal root repair is Disallowed if performed on a permanent tooth or if performed on the same date of service by the same Dentist/dental office as an apicoectomy or retrograde filling.

16. Retrograde fillings are a covered benefit once per root per three (3) years. The fee for retreatment within twenty-four (24) months of the original procedure by the same Dentist/dental office is Disallowed.

17. The fee is Disallowed for periradicular surgery without an apicoectomy performed on the same tooth, on the same date, by the same Dentist/dental office as an apicoectomy, retrograde filling and/or root amputation.

18. .Clinical crown lengthening is a covered benefit once per tooth in a three (3) year period and only when performed in a healthy periodontal environment in which bone must be removed for placement of the restoration or crown, or prosthetic device. The fee for clinical crown lengthening is Disallowed if performed on the same date of service by the same Dentist/dental office as the crown placement.

19. Clinical crown lengthening, when done in conjunction with osseous surgery, crown preparations, or restorations is considered a component of, and included in the fee for, the complete procedure. A Participating Dentist agrees not to charge a separate fee.

20. Clinical crown lengthening, when performed in conjunction with other periodontal procedures, will be subject to a dental consultant's review. Payment will be based on the most comprehensive procedure.

21. An interim partial or complete denture is not a covered benefit. Fees are Disallowed if billed in conjunction with a permanent appliance.

22. If abutment teeth have moved to partially close an edentulous area, only the number of pontics necessary to fill that area are a covered benefit. The patient will be responsible for any additional fee.

23. The fee for sectioning of a fixed partial denture in order to remove the denture prior to placing a new denture is Disallowed. Sectioning of a fixed partial denture to preserve a portion of the denture for continued use may be covered but is subject to review by a dental consultant.

24. An implant body, including healing cap, is a benefit once in a five (5) year period for enrollees age sixteen (16) and older.

25. Implant services and implant supported prosthetics are not a covered benefit for patients under the age of sixteen (16).

26. Removal of an implant is a covered benefit once in a five (5) year period per tooth site.

Please note: ***Certain procedures for Pediatric Enrollees as expressly identified require Prior Authorization from Delta Dental. Separate from any required Prior Authorization, Delta Dental encourages Predetermination of cases involving costly or extensive treatment plans. Although not required, Predetermination helps avoid confusion regarding Delta Dental's payment and your financial obligation to the Dentist.***

Orthodontic Benefits (Coverage D).

Medically Necessary Orthodontia for Pediatric Enrollees only.

Medically Necessary Orthodontic treatment and procedures used for the correction of malposed (crooked) teeth, including the placement of a device to facilitate eruption of an impacted tooth. Medically Necessary Orthodontic treatment and procedures are subject to Prior Authorization.

Medically Necessary Orthodontic Benefits (for Pediatric Enrollees only) - Exclusions and Limitations.

- If the fee for a procedure or service is **"Disallowed"**, it is not payable by Delta Dental, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is **"Denied"**, it is not payable by Delta Dental, but is chargeable to the patient as the procedure or service is not a benefit of the patient' plan.

1. For Medically Necessary Orthodontic treatment commenced while a Pediatric Enrollee is eligible for orthodontic benefits under this policy, Delta Dental will initiate payment of its liability once bands or orthodontic devices are placed. Delta Dental requires a dental consultant's review to determine if orthodontic treatment is medically necessary.
2. For Medically Necessary Orthodontic treatment commenced prior to becoming eligible under this policy, Delta Dental will pro-rate its liability based on the number of remaining months of active treatment compared to the total number of months of active treatment. Delta Dental requires dental consultant review to determine if orthodontic treatment was medically necessary at the start of treatment.
3. Active treatment includes procedures undertaken and appliances used with those procedures for the purpose of bringing teeth into proper position and alignment. Active treatment does not include space maintainers, palate expanders, or other devices used to prepare the patient for services to position and align teeth.
4. Delta Dental will make one (1) payment of twenty-five percent (25%) of the allowed charge at the start of treatment followed by monthly payments throughout the length of treatment up to a maximum of thirty-six (36) months for its total liability. "Start of treatment" means the date of initial banding or a segment thereof, or a device is placed in the patient's mouth. Periodic monthly payments will continue based upon the continuing eligibility of the Pediatric Enrollee.
5. Cephalometric images, oral/facial photographic images and diagnostic models are a covered benefit with Medically Necessary Orthodontic treatment only.
6. The replacement of an orthodontic appliance is a covered benefit once per arch in a lifetime.
7. The repair of an orthodontic appliance is not a covered benefit. The patient is financially responsible.
8. Rebonding or recementing of a fixed retainer is a covered benefit once in a lifetime if performed by a different Dentist than the Dentist who placed the appliance. Rebonding or recementing of a fixed retainer by the same Dentist/dental office who placed the original appliance is Disallowed.
9. Repair of a fixed retainer (including reattachment) is a covered benefit once in a lifetime per patient if performed by a different Dentist/dental office than the one who placed the appliance. Repair of a fixed retainer by the same Dentist/dental office who placed the original appliance is Disallowed.

Please note: ***Certain procedures for Pediatric Enrollees as expressly identified require Prior Authorization from Delta Dental. Separate from any required Prior Authorization, Delta Dental encourages Predetermination of cases involving costly or extensive treatment plans. Although not required, Predetermination helps avoid confusion regarding Delta Dental's payment and your financial obligation to the Dentist.***

VI. Waiting Periods and General Exclusions and Limitations.

1. Waiting Periods.

The waiting periods with your benefits are noted in the Contract Application. A waiting period of three (3) months applies to Adult Enrollees only and only in connection with Basic Restorative Benefits. A waiting period of six (6) months applies to Adult Enrollees only and only in connection with Major Restorative Benefits. There are no waiting periods for Adult Enrollees in connection with Diagnostic and Preventive Benefits. There are no waiting periods for Pediatric Enrollees in connection with Diagnostic and Preventive, Basic Restorative or Major Restorative Benefits. There is a twenty-four (24) month waiting period in connection with Medically Necessary Orthodontic benefits for Pediatric Enrollees.

2. Application of Waiting Periods Due to Change in Coverage.

If you had a dental plan for at least six (6) months and within thirty (30) days prior to the Effective Date of this plan, the waiting periods for the same Basic and Major Restorative Benefits will be deemed satisfied under this plan for each Adult Enrollee also covered under your prior coverage.

3. The dental benefits provided by Delta Dental shall **not include** the following services.

(a) Services for injuries or conditions compensable under Worker's Compensation or Employer's Liability laws are not a covered benefit.

(b) Services that are determined by Delta Dental to be provided for cosmetic reasons are not a covered benefit. This includes bleaching or whitening of teeth (unless discolored by previous endodontic therapy), placement of veneers, correction of congenital malformations, or cosmetic surgery. This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.

(c) Services completed when Enrollees were not covered under this policy are not a covered benefit. Such services include, but are not limited to, endodontics and prosthodontics (including restorative crowns and onlays).

(d) Services not provided by a Dentist, an independent practice dental hygienist, a dental hygiene therapist, or under the supervision of a Dentist, or not within the scope of the license of the Dentist, the independent practice dental hygienist, a dental hygiene therapist, or the person supervised by the Dentist are not a covered benefit, unless otherwise required by law.

(e) Charges for prescription drugs or the application of anti-microbial agents are not a covered benefit.

(f) Charges for: (i) hospitalization; (ii) preventive control programs; (iii) myofunctional therapy; (iv) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (v) equilibration; and (vi) gnathological reporting are not a covered benefit.

(g) Charges for failure to keep a scheduled visit with the Dentist are not a covered benefit.

(h) Charges for completion of forms are not a covered benefit. Such charges shall not be made to an Enrollee by Participating Dentists.

(i) Dental Care which is not necessary and customary, as determined by generally accepted standards of dental practice are not a covered benefit.

(j) Dental Care or supplies not within the benefits for the option selected are not a covered benefit.

(k) Appliances, procedures, or restorations for: (i) increasing vertical dimension; (ii) analyzing, altering, or restoring occlusion; (iii) replacing tooth structure lost by attrition or abrasion; (iv)correcting congenital or developmental malformations; or (v) esthetic purposes are not a covered benefit. This exclusion is not intended to exclude services to newborn children for congenital defects or birth abnormalities.

(l) Payments of benefits incurred by you or the Enrollee after the date on which the Enrollee becomes ineligible for benefits are not a covered benefit.

(m) Charges for Dental Care or supplies for which no charge would have been made in the absence of dental benefits are not a covered benefit.

(n) Charges for Dental Care or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared are not a covered benefit.

(o) Temporary services are not a covered benefit.

(p) A treatment that is incomplete is not a covered benefit.

(q) A consultation is not a covered benefit, unless being done by someone who is not performing further services.

(r) Case presentation and treatment planning are not a covered benefit. You or the Enrollee will be responsible for any additional fee.

(s) Athletic mouthguards are not a covered benefit.

4. The dental benefits provided by Delta Dental shall be limited as follows unless otherwise required by Maine law.

(a) Dental Care provided by anyone other than a Dentist shall not be a benefit, except that scaling or cleaning of teeth and topical application of fluoride and such other treatment performed by a licensed dental hygienist shall be a benefit, so long as either:

i. The treatment is provided under the supervision and guidance of a Dentist, in accordance with generally accepted standards of dental practice.

ii. The treatment is provided by an independent practice dental hygienist within the lawful scope of practice of that independent practice dental hygienist.

iii. The treatment is provided by a dental hygiene therapist within the lawful scope of practice of that dental hygiene therapist.

(b) Optional Dental Care. In all cases in which you and/or the Enrollee, after consultation with your Dentist, agree to more expensive Dental Care than customary, Delta Dental will pay the Coinsurance Percentage for the Dental Care which is usually given to fix the tooth to contour and function. You and/or the Enrollee shall pay the remainder of the Dentist's fee.

(c) Predetermination and Prior Authorization do not guarantee payment. Payment is based on eligibility, benefits selected, and allowable charges at the time the Dental Care is provided. If Coordination of Benefits is involved, the amount of payment is subject to change based on the payment made by the primary carrier.

(d) Services completed at the Enrollee's date of death will be paid in full to the limit of Delta Dental's liability.

(e) When services for Dental Care in progress are interrupted and completed at a later date by another Dentist, Delta Dental will review the claim to decide what payment, if any, is due to each Dentist.

(f) Specialized techniques such as precision attachments, overdentures and associated procedures, and personalizations or characterization are excluded. You and/or the Enrollee will need to pay for part of or the entire fee for these services.

(g) Interpreter services are a covered benefit when they are done at the same time as other covered services. Interpreter services are a covered benefit for Pediatric Enrollees only.

(h) Delta Dental programs provide amalgam (silver) and resin (white) restorations (fillings) for treatment of caries. If a white filling is performed, an allowance of the cost of a silver filling will be paid towards the cost of the white filling and the patient will be responsible for payment of the balance. If the teeth can be restored with such materials, any gold restorations, or crowns are considered optional. You and the Enrollee will need to pay for any additional fee.

(i) Notice of sickness or of injury must be given to Delta Dental within twenty (20) days after the date when such sickness or injury occurred or as soon as reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

(j) Delta Dental, upon receipt of a notice of claim, will furnish to you such forms usually furnished by it for filing claims. If such forms are not furnished within fifteen (15) days after you give such notice, you shall be deemed to have complied with the requirements of this policy with the time fixed in the policy for filing claims. Notice given by or on behalf of you to Delta Dental, or to any authorized agent of Delta Dental, with information sufficient to identify you, shall be deemed notice to Delta Dental.

(k) A completed claim must be furnished to Delta Dental within twenty-four (24) months from the date the Dentist provided Dental Care. No payment will be made on claims with dates of service in excess of the twenty-four (24) months.

(l) The Date of Incurred Liability is the date a service is subject to the Deductible, Co-Payment, Coinsurance Percentage, and limitations. Except as otherwise noted, the total cost of the service is applied to the Plan Year during which the service is completed, regardless of the Plan Year in which the service is started.

For services covered, Delta Dental's payment for multiple visit procedures is based on the following dates.

(i) Crowns. The total cost for crowns is based on the date that the crown is cemented. Pediatric Enrollees under the age of twelve (12) need a Prior Authorization.

(ii) Fixed Partial Dentures. The total cost for fixed partial dentures is based on the date that the dentures are cemented.

(iii) Removable Complete and Partial Dentures. The total cost for removable complete and partial dentures is based on the date that the dentures are given to the patient.

(iv) Endodontics (root canal). The total cost for a root canal is based on when the tooth canal is filled.

(v) Implants for Enrollees age sixteen (16) and older. The total cost for implants is based on the date the implant was surgically placed.

(vi) Implant Prosthetics for Enrollees age sixteen (16) and older. The total cost for the implant prosthetic is based on the date that the prosthetic is cemented or given to the patient.

VII. Coordination of Benefits (Dual Coverage).

The Coordination of Benefits provision is designed to provide maximum coverage, but not to exceed 100% of the total fee for a given service. In the event that an Enrollee is entitled to benefits under any other health care program, the following Coordination of Benefits provision shall determine the sequence and extent of payment. Other health care programs may include any other sponsored plan or group insurance plan.

When an Enrollee is covered under another health care program, the following rules shall be followed to establish the order of determining liability.

1. When only one plan has a Coordination of Benefits provision, the plan without such provision shall determine its benefits first.
2. The plan covering an Enrollee solely as an employee shall determine its benefits before the plan which covers the Enrollee solely as a Dependent.
3. The plan covering the Enrollee solely as a Dependent of the parent whose birthdate occurs earlier in a calendar year shall determine its benefits before the plan covering the Enrollee solely as a Dependent of the parent whose birthdate occurs later in a calendar year ("Birthday Rule"). A parent's year of birth is

not relevant. If both parents have the same birthdate (month and day) the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time. If the other health care program does not use the Birthday Rule, then that plan's provisions will determine the order of liability.

4. If paragraphs 1 through 4 above do not establish an order of benefit determination, the benefits of the plan which has covered the Enrollee for the longer period of time shall be determined first.

5. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows.

   a. For a dependent child whose parents are married or are living together.

      1. The plan of the parent whose birthday is earlier in the calendar year is the primary plan.

      2. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

   b. For a dependent child whose parents are divorced, separated or do not live together, whether or not they have ever been married.

      1. If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

      2. If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of paragraph 5. a. shall determine the order of benefits.

      3. If a court decree states that the parents have joint custody without specifying that one parent is responsible for the health care expenses or health care coverage of the child, the provisions paragraph 5. a. shall determine the order of benefits.

      4. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

         (i) The plan covering the custodial parent;

         (ii) The plan covering the custodial parent's spouse;

         (iii) The plan covering the non-custodial parent; and then

         (iv) The plan covering the non-custodial parent's spouse.

   c. For a child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined under subparagraph a. or b. of this paragraph as if those individuals were parents of the child.

6. When Delta Dental is the first to determine its benefits under the foregoing, benefits hereunder shall be paid without regard to Coverage under any other plan. When Delta Dental is not the first to determine its benefits and there are remaining expenses of the type allowable, Delta Dental will pay only the amount by which its benefits exceed the amount of benefits payable under the other plan up to the amount Delta Dental would have paid without regard to the payment by the other plan or the amount of such remaining expenses, whichever is less. In other words, the combined payment of both plans will not exceed the total cost of the service.

   Delta Dental may use reasonable efforts to determine the existence of other benefit programs but are not required to do so. The Enrollee is required to furnish Delta Dental with information relative to any other health care program in order to determine liability.

7. For the purpose of determining the applicability and implementing the terms of this provision in the Agreement, Delta Dental may release or obtain from any third party, without consent or notice, any information which it deems to be necessary to determine its liability. Delta Dental shall be free from any liability that might arise in relation to such action.

8. Multiple Coverage. When benefits are coordinated with another Delta Dental plan, or any other plan providing dental benefits, time limitations and frequency of service limitations will not change. Coverages for services for which a specified number are provided per a specified time period shall not be added together to provide more than the number of services specified per time period under this plan. For example, if each plan covers one cleaning in a six month period, the combined Coverages will still only cover one cleaning in any six month period. If such a service is covered under this plan, but has been paid for, whether in full or part, by another plan, such service will still be counted toward the maximum number of such services allowed per period under this plan.

9. Right of Recovery. Delta Dental has the right to recover from the payee excess benefit payments.

10. Subrogation. In the event of any payments for Dental Care under this Agreement, with the prior written approval of the Subscriber or Eligible Dependent, Delta Dental shall be subrogated to all the Subscriber's or Eligible Dependent's right of recovery thereof against any third person or organization who may be liable for such payment. The Subscriber or Eligible Dependents shall execute and deliver such instruments and papers and do whatever else is necessary to secure such rights. Such subrogation shall be on a just and equitable basis and not on the basis of a priority lien.

VIII. General Claims Inquiry.

After a claim is sent by your Dentist and processed by Delta Dental, you or the Enrollee will have access to an Explanation of Benefits. This notice will explain the benefits paid on your behalf, it will also let you know of any Denied or Disallowed services, and give you the reason for any denial or disallowance.

If you have any questions about your benefits, you may call Delta Dental at 603-223-1234. The toll-free number is 1-800-832-5700. You will be connected to our Customer Service.

The Customer Service Representative will need to know the claim number that is on your Explanation of Benefits. If that is not available, please give your Subscriber ID number and the date of treatment. This will allow a quick answer to your question.

IX. Disputed Claims Procedure.

If you have reason to believe your benefit determination was not in accordance with the terms of this policy, you have the option of using Delta Dental's Disputed Claims Procedure. This may be requested within six (6) months of the date of Delta Dental's original Explanation of Benefits. We recommend that your written request for a review of your claim be personally delivered or mailed certified mail, return receipt requested, to the Vice President, Professional Relations, Northeast Delta Dental, One Delta Drive, PO Box 2002, Concord, New Hampshire, 03302-2002. You may also submit your request by standard mail.

Your request for a review of your claim should refer to the claim(s) in question, state your name and address, and the reasons you think the denial should be evaluated. You may provide any additional materials you wish to present.

The Vice President, Professional Relations, or his designee, will promptly review your claim. He may request additional documents as necessary to make such a review. If the claim is denied in any respect, you will be furnished with a written notice of the decision within thirty (30) days after receipt of the disputed claim. The notice will include:

1. The specific reason(s) for denial.

2. The specific reference to the provision of this Agreement upon which the denial is based.

If your request results in an additional payment, it will be made within fifteen (15) working days of the response from the Vice President, Professional Relations.

If you do not receive notice within the thirty (30) day period, the claim is considered denied in order that you may proceed to the Disputed Claims Review Procedure.

If you have any problem securing a review of your claim, you may also contact:

Department of Professional & Financial Regulation
Bureau of Insurance
#34 State House Station
Augusta, ME 04333-0034
1-800-300-5000 (toll free in Maine) or 207-624-8475
Fax: 207-624-8599
http://www.state.me.us/pfr/insurance/index.shtml

X. Disputed Claims Review Procedure.

The Disputed Claims Review Procedure allows you to request a review from Delta Dental's Disputed Claims Review Committee. The request can be made on your denied claim after following the Disputed Claims Procedure. The Review Committee is a group of Participating Dentists, non-dentist members of the Board of Directors, and representatives of purchasers.

You or your authorized representative may appeal to the Review Committee by filing a request for review within one hundred eighty (180) days after denial of your claim following the Disputed Claims Procedure. We recommend that your written request should be sent certified mail to the Review Committee at Delta Dental's address. You may also submit your request by standard mail. It must state the reasons for requesting a review. It should contain the issues, comments, and supporting materials stating why you believe the response of the Northeast Delta Dental Vice President, Professional Relations was incorrect. A decision will be provided within thirty (30) days after receipt of your request. The decision of the Review Committee will be in writing and will include specific reasons for the decision.

In addition, or as an alternative to the written request, you may request a hearing from the Review Committee to consider matters raised in your appeal. At the hearing, you are entitled to representation by a lawyer or other representative, to request a stenographer to transcribe the hearing, to present evidence, to request the testimony of witnesses and to cross-examine witnesses. You or your representative may review the policy and related pertinent documents. The hearing will be scheduled with prompt written notice to you no later than thirty (30) days after your request. A decision will be provided within thirty (30) days after the hearing. The decision of the Review Committee will be in writing and will include specific reasons for the decision.

Notice of Right to Appeal Your Health Insurer's Final Decision.

You may have a legal right to have our decision reviewed by an organization that is neutral. This is called Independent External Review.

You must ask for this Independent External Review no later than one year after receiving the notice of internal review denial.

Call the Department of Professional & Financial Regulation at 1-800 300-5000 to ask for this review.

Department of Professional & Financial Regulation
Bureau of Insurance
#34 State House Station
Augusta, ME 04333-0034
1-800-300-5000 (toll free in Maine) or 207-624-8475

XI. General Conditions.

Assignment.

Benefits are personal and cannot be transferred from one Enrollee to another.

Right of Recovery.

Delta Dental will succeed to the Enrollee's right of recovery against any third person or organization that may be liable.

Physical Examinations.

In consideration of waiving a physical examination of you or your Dependent(s) and as a condition precedent to the approval of claims, Delta Dental shall be allowed to receive, to such extent lawful from any Dentist or from hospitals in which a Dentist's service is provided. Such information and records relating to attendance of, or examination of, or treatment given to such person as may be required to process such claim. Delta Dental is responsible for such information and records. Delta Dental shall have the right to examine the insured, at its own expense, when and as often as it may reasonably require while a claim for the insured is pending. Delta Dental shall preserve the privacy of such information except as is necessary for the proper administration of Delta Dental plans.

Doctor-Patient Relationship.

You have the freedom to choose any Dentist or ODP. Dentists and ODPs providing services under the Agreement are independent contractors and will maintain the traditional doctor-patient relationship. The Dentist or ODP will be responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility during Treatment.

If a Dependent loses their eligibility while receiving treatment, only covered services received while eligible will be considered for payment. A Dependent under your policy may lose eligibility if such person ceases to be eligible in accordance with the provision of Section II. 16. of this policy, and the policies of HHS.

Maintaining Your Privacy.

Delta Dental has always respected and preserved the privacy and confidentiality of Subscribers and their Dependents. As part of that protection, Delta Dental is in compliance with all state and federal laws regarding privacy of personal and health information is maintained.

By receiving coverage through this dental plan, each Enrollee, including a parent or guardian in the case of a minor Dependent, agrees that, except as restricted by state and federal laws, Delta Dental may have access to all dental and health records, and medical data from Dentists, ODPs, and other health care providers providing services covered under this dental plan.

For a copy of Delta Dental's Notice of Privacy Practices, please visit our website www.nedelta.com. If you wish to have a copy mailed to you or have any questions about the privacy of your personal or health information, please contact:

Privacy Officer
Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
1-800-537-1715

Entire Agreement; Amendment.

This Certificate of Insurance, together with the Contract Application, constitutes the entire contract of insurance. This Certificate of Insurance is subject to the Maine Bureau and FFM requirements and modifications. Additionally, we reserve the right to implement changes in American Dental Association (ADA) dental terminology and CDT codes and Delta Dental internal processing policies which do not materially affect the provisions of this Certificate. Any material change in this Certificate of Insurance shall be valid only if approved

by the Maine Bureau and an executive officer of Delta Dental. Any material change evidenced by a written, signed amendment hereof or endorsement hereto. Any such amendment or endorsement will be provided to you at least sixty (60) days in advance of its effective date. No broker or agent has authority to change this Certificate of Insurance or waive any of its provisions.

Governing Law.

This policy is governed by and shall be construed according to, the laws of the state of Maine and its regulations. This dental plan is under the jurisdiction of the Superintendent of the Maine Bureau.

Notice of Legal Action.

You may not bring a legal action against Delta Dental under this policy until sixty (60) days after the notice of claim. No such action shall be brought after the expiration of three (3) years after the time written notice of claim is required to be furnished.

Nonwaiver of Rights: Severability.

Failure of Delta Dental to exercise any right or remedy under this policy in any instance will not affect its right to exercise that right or remedy in any future instance. Any condition, limitation, exclusion or other provision of this policy which is found to be illegal or unenforceable for any reason will not affect the remaining provisions of this policy.

Incontestability.

After three (3) years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by you in the application for such policy shall be used to void the policy or to deny a claim commencing after the expiration of such three (3) year period.

Cognitive Impairment or Functional Incapacity – Notice of Rights:

Under Maine law, a person with a mental or nervous disorder with a demonstrable organic origin causing cognitive impairment or functional incapacity, including, but not limited, to Pick's Disease, Parkinson's Disease, Huntington's Chorea or Alzheimer's Disease and related dementias (a "Cognitive Impairment or Functional Incapacity") has certain rights with respect to his or her coverage under this policy. The following are a list of those rights.

(a) to designate a third party to receive notice of cancellation of this policy;

(b) to change the designated third party upon written request sent or given to Delta Dental;

(c) to reinstatement of this policy if the coverage was cancelled due to non-payment of premium or other default.

Within ten (10) days of a request by an insured, Delta Dental will mail or cause to be personally delivered a Third Party Notice Request Form. In the event that coverage under this policy is to be terminated, Delta Dental shall provide, in addition to any other notice to the insured required by law, a notice of the pending cancellation to any third party properly designated by a covered person having a Cognitive Impairment or Functional Incapacity. Such notice shall contain all information required by law and shall be at least twenty-one (21) days prior to the expiration of the payment grace period.

If a request for reinstatement of coverage is denied, notice shall be provided to the subscriber, to any designated third party, and to the person making the request. The denial shall include notification of a thirty (30) day period once the denial is received during which a hearing before the Superintendent may be requested.

XII. Assignment of Benefits.

Benefits will be paid directly to a Participating Dentist. If the Dentist or Other Dental Provider does not participate with Delta Dental, payment will be made to the Subscriber unless the state in which the services were provided requires that assignment of benefits be honored. Delta Dental must receive written notice of an assignment on the claim form before payment for benefits is made.

Northeast Delta Dental
Delta Dental Plan of Maine
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
www.nedelta.com

Customer Service
603-223-1234
1-800-832-5700
TTY/Hearing Impaired
1-800-332-5905

Corporate Office
603-223-1000
1-800-537-1715
Fax: 1-800-223-1199