

Delta Dental PPO (Point-of-Service) Summary of Dental Plan Benefits For Group# 92001-1000 Ohio Delta Individual Graduated Low Plan

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies, and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental allowance for each service and it may vary due to the dentist's network participation.*

Control Plan - Delta Dental of Ohio

Benefit Year - Your benefit year begins on your effective date and ends after 12 consecutive months. You will have a new benefit year every 12 consecutive months thereafter.

Covered Services -

- Delta Dental PPO Dentist
- Delta Dental Premier Dentist
- Nonparticipating Dentist*

	1 st Year	2 nd Year +
	Plan Pays	Plan Pays
Diagnostic & Preventive		
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%
Radiographs - X-rays	100%	100%
Basic Services		
Minor Restorative Services - fillings and crown repair	50%	70%
Oral Surgery Services - extractions and dental surgery	50%	70%
Other Basic Services - misc. services	50%	70%
Relines and Repairs - to prosthetic appliances	50%	70%
Major Services		
Endodontic Services - root canals	35%	50%
Periodontic Services - to treat gum disease	35%	50%
Major Restorative Services - crowns	35%	50%
Prosthodontic Services - bridges, implants, dentures, and crowns over implants	35%	50%

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per benefit year.
- Prophylaxes (cleanings) are payable twice per benefit year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per benefit year for people age 18 and under.
- Bitewing X-rays are payable once per Benefit Year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are

available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment -

1st Year - \$800 per person total per year on all services.

2nd Year and after - \$1,000 per person total per year on all services.

Deductible - \$50 Deductible per person total per year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, and X-rays.

SUMMARY



Delta Dental Plan of Ohio, Inc.
P.O. Box 30416
Lansing, MI 48909-7916

OHIO AGREEMENT AND CONSIDERATION

Your dental coverage is underwritten by Delta Dental Plan of Ohio, Inc., an Ohio non-profit health-insuring corporation (hereinafter referred to as "Delta Dental"). Delta Dental will pay Benefits for Covered Services as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first premium. It takes effect on the Effective Date shown on your Summary of Dental Plan Benefits. It will remain in force for such further periods as when it is renewed automatically upon payment of premium. All periods will begin and end at 12:01 A.M. Standard Time where you live.

10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this Policy. If you are not satisfied, you may return the Policy within 10 days after you received it. Mail or deliver it to Delta Dental or to your agent. Any premium paid will be refunded. This Policy will then be void from its start.

This Policy is signed for the underwriting company, Delta Dental Plan of Ohio, Inc. as of its Effective Date.

President & Chief Executive Officer
Delta Dental Plan of Ohio, Inc.

**THIS DENTAL POLICY IS CONDITIONALLY RENEWABLE REFER TO RENEWABILITY AND
TERMINATION PROVISION
READ YOUR POLICY AND SUMMARY OF DENTAL PLAN BENEFITS CAREFULLY**

This Policy is a legal contract between the Insured and Delta Dental Plan of Ohio, Inc.

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

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SAMPLE

DEFINITIONS

- A. **Allowed Amount** –The amount permitted under the applicable fee schedule for this Policy upon which Delta Dental will base its payment for a Covered Service. We determine the Allowed Amount based on treatment rendered and fees charged by a sample of Dentists of similar training within your geographic area.
- B. **Benefit Year** – The period during which any Benefit frequency limitation and/or annual Maximum Payment will apply. This will be the calendar year, unless otherwise indicated on the Summary of Dental Plan Benefits. If the Benefit Year is based upon a calendar year, the terms Benefit Year and Calendar Year may be used interchangeably.
- C. **Benefits** – Payment for the Covered Services under the Policy.
- D. **Child(ren)** – Your natural child(ren), stepchild(ren), adopted child(ren), foster child(ren) placed in the foster home, or child(ren) by virtue of legal guardianship, including child(ren) who is/are residing with you during the waiting period for legal adoption or guardianship.
- E. **Claim** – A request for payment for a Covered Service. Claims are not conditioned upon you seeking advance approval, certificate, or authorization to receive payment for any Covered Service.
- F. **Coinsurance** – The percentage of the Allowed Amount for Covered Services that you must pay toward treatment.
- G. **Completion Date** – The date that treatment is complete. Some procedures may require more than one appointment before treatment can be completed. Treatment is complete:
- For x-rays and procedures, on the delivery date;
 - For crowns and bridge work, on the cementation date;
 - For root canals and periodontal treatment, on the date of the final procedure that completes treatment.
- H. **Copayment** – A fixed amount you pay for a Covered Service after you've paid your Deductible.
- I. **Covered Services** – The unique dental services selected for Benefits as described in the Summary of Dental Plan Benefits and subject to the terms and conditions of this Policy.
- J. **Deductible** – The amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for services under this Policy. The Deductible amount is shown in the Summary of Dental Plan Benefits.
- K. **Delta Dental** –Delta Dental Plan of Ohio, Inc., a nonprofit health-insuring corporation. Delta Dental Plan of Ohio, Inc. is not a commercial insurance company.
- L. **Delta Dental Member Plan** – A company that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.
- M. **Delta Dental PPO Dentist Schedule** – The maximum fee allowed per procedure for services rendered by a Delta Dental PPO Dentist as determined by that Dentist's local Delta Dental Member Plan.
- N. **Delta Dental® Premier Dentist Schedule** –The maximum fee allowed per procedure for services rendered by a Delta Dental Premier Dentist as determined by that Dentist's local Delta Dental Member Plan.
- O. **Dentist** – A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.
- Delta Dental PPO Dentist** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental PPO.
2. **Delta Dental Premier Dentist** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental Premier.
 3. **Nonparticipating Dentist** – a Dentist who has not signed an agreement with any Delta Dental Member Plan to participate in Delta Dental PPO or Delta Dental Premier.
 4. **Out-of-Country Dentist** – a Dentist whose office is located outside the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.
- Delta Dental PPO Dentists and Delta Dental Premier Dentists are sometimes collectively referred to herein as “Participating Dentists.” Wherever a definition or provision of this Policy differs from another state’s Delta Dental Member Plan and its agreement with Participating Dentists, the agreement in that state with that Dentist will be controlling.
- Delta Dental Premier Dentists, Nonparticipating Dentists, and Out-of-Country Dentists are sometimes collectively referred to herein as “Non-PPO Dentists.”

P. Deny/Denied/Denial

When a Claim for a particular service is denied for payment due to certain contractual limitations/exclusions. You will be responsible for paying your Dentist the applicable amount for such service regardless of the Dentist's participating status.

Q. Dependent - means:

1. Your Spouse;
2. Your unmarried Children who have not yet reached the end of the [month][calendar year][benefit year] of their [19th - 30th] birthday.
3. Any unmarried Children for whom you or your Spouse are financially responsible for the medical, health, or dental care under the terms of a court decree or who have been named as alternate recipients under a qualified medical child support order; or
4. Your Children who have reached the end of the [month][calendar year][benefit year] of their [19th - 30th] birthday but who were at that time (and continue to be) totally and permanently disabled by a physical or mental condition. Those Children must also be eligible to be claimed by you or your Spouse as dependents under the U. S. Internal Revenue Code during the current calendar year. If Delta Dental asks you to do so, you must submit medical reports confirming the Child's initial and continuing total disability; provided however, that Delta Dental will not ask you to do so more than once a year.

R. Eligible Person(s) or Member(s) - The Insured or any Dependent who is covered under this Policy.

S. Insured - The person named on the application (some may be referred to herein as "you" or "your").

T. Maximum Approved Fee - The Maximum Approved Fee is the lowest of:

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

Participating Dentists agree not to charge Delta Dental patients more than the Maximum Approved Fee for the Covered Service. In all cases, Delta Dental will make the final determination about what is the Maximum Approved Fee for a Covered Service.

U. Maximum Payment - The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. See the Summary of Dental Plan Benefits for the Maximum Payment applicable to this Policy.

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

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

X. Out-of-Pocket Maximum - The maximum amount that you or your dependent will pay for Covered Services during a Benefit Year as set forth in your Summary of Dental Plan Benefits.

Y. Plan - The arrangement for the provision of benefits to eligible people established by this Policy between Delta Dental and the Insured.

Z. Policy - This document issued and delivered to the Insured. It includes the attached pages, the application, the Summary of Dental Plan Benefits, and any attached amendments.

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

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

Availability of dental benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, this Policy's limitations and any other provisions, together with any

additional information or changes to the dental treatment. A request for a Pre-Treatment Estimate is not a Claim or a preauthorization, precertification or other reservation of future Benefits.

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

CC. Spouse - Your legal spouse.

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

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

INSURED PERSON'S ELIGIBILITY

The persons insured on the effective date of this Policy will be the Insured and Dependents named on the application that has been approved by Delta Dental. The Summary of Dental Plan Benefits will have specific information about this Policy's rules for dependent eligibility. This Policy will be classified as follows:

- Individual Plan - Insured only
- Individual plus Spouse Plan - Insured and Spouse only
- Individual and One Child Plan
- Individual and Two Children Plan
- Individual and Three or more Children Plan
- One Child Family Plan - Insured, Spouse, and one Child
- Two Child Family Plan - Insured, Spouse, and two Children
- Three or more Children Family Plan - Insured, Spouse, and three or more Children

ADDING COVERED PERSONS

Adding an Adult (A Parent or Spouse): The Insured may add an adult to the Policy, including your Spouse or a parent of insured Children. You must submit an application for Delta Dental approval and pay the added premium that is required. The adult will not be insured until Delta Dental (1) approves the application; and (2) gives written notice to you that the Policy is changed; and (3) receives the required premium.

The effective date of coverage will be on the written notice sent to you.

Adding a Newborn or Adopted Child: A newborn or adopted Child will be covered from the time of his or her birth or the earlier of the date of placement for adoption or the date of an entry of an order granting you custody of the Child for purposes of adoption until the 31st day after his or her birth or placement or entry of an order granting custody for adoption. A newborn or adopted Child may continue as a covered person after 31 days only if the following conditions are satisfied:

You must ask for a Policy change and pay the increase in premium (if any). This must be done by the 31st day after the Child's birth or placement for adoption. If this is not done, the newborn or adopted Child will cease to be dependent as of the end of the 31st day.

Adding a Child Under Guardianship: A Child for whom you or your Spouse is a court-appointed guardian will be covered from the time of the filing of the application for appointment of guardianship with a court of competent jurisdiction, subject to the terms of the Policy, until the 31st day after that date, unless the guardianship is disrupted prior to the date the court appoints you or your Spouse as guardian and the Child is removed from your or your Spouse's physical custody. The Child may continue as a Dependent after the 31st day only if Delta Dental has received both written notice of the Child's pending guardianship status and any additional premium required.

Adding Other Eligible Children: To add any other Child as a Dependent, you must: (1) submit an application for Delta Dental approval; and (2) pay any added premium that Delta Dental may require. The Child will not become a Dependent until Delta Dental has given notice to you of our approval, and Delta Dental has received the required premium. The effective date of coverage will be in the written notice sent to you.

SELECTING A DENTIST

You may choose any Dentist. Your out-of-pocket costs are likely to be less if you go to a Delta Dental Participating Dentist.

If a Participating Dentist is not readily available within a reasonable period of time or driving distance, it may be possible to receive Covered Services from a Nonparticipating Dentist and be reimbursed at the same benefit level as if the Covered Services were provided by a Participating Dentist. If you feel this may be the case, please call Delta Dental's Customer Service Department, toll-free, at [800-971-4108 (TTY users call 711)] or write to them at [P.O. Box 1596, Indianapolis, Indiana, 46206]. We will review your situation and, if appropriate, authorize payment for a Nonparticipating Dentist at the Participating Dentist benefit level.

To verify that a Dentist is a Participating Dentist, you can use Delta Dental's online Dentist Directory at [www.deltadentaloh.com] or call [800-971-4108 (TTY users call 711)].

PRE-EXISTING CONDITIONS AND NONDISCRIMINATION

No Person will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, age, race, color, national origin, gender identity, sex, or sexual orientation.

ACCESSING YOUR BENEFITS

To utilize the coverage under your Policy, follow these steps:

1. Please read this Policy and the Summary of Dental Plan Benefits carefully so you are familiar with the Benefits, payment methods, and terms of your Policy.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits with Delta Dental. If your Dentist is not familiar with your coverage or has questions about the Policy, have him or her contact Delta Dental by (a) writing Delta Dental, Attention: [Customer Service, P.O. Box 1596, Indianapolis, Indiana 46206], or (b) calling the toll-free number, [800-971-4108 (TTY users call 711)].

Claim Forms: Delta Dental does not require special Claim forms. However, most dental offices use Claim forms available. Participating Dentist offices will fill out and file Claim forms for you. You may have to submit your own Claim form if you receive treatment from a Nonparticipating Dentist. Claim forms are available at Delta Dental's website, [www.deltadentaloh.com], or you can contact Customer Service at [800-971-4108 (TTY users call 711)] to request one.

Delta Dental, upon receipt of a notice of Claim, will furnish the claimant with forms that are usually furnished by it for filing proofs of loss. If such forms are not received within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which Claim is made.

Notice of Claim: After you receive your dental treatment, you or the dental office staff will file a Claim form, completing the information portion with:

1. The Insured's full name and address
2. The Insured's Social Security number

3. The name and date of birth of the person receiving dental care
4. The Policy number

Proof of Loss: Mail Claims and completed information requests to:

**Delta Dental
[P.O. Box 9085
Farmington Hills, MI 48333-9085]**

All Claims for Benefits must be filed within 12 months of the date the services were completed, unless the claimant was incapacitated. If it was not reasonably possible to file written proof within the time allowed, we shall not reduce or Deny the Claim for this reason if the proof is provided as soon as reasonably possible. Claims not filed within one year of the date the services were completed will be Denied if the services were performed by a Nonparticipating Dentist, or are not chargeable to the patient if the services were performed by a Participating Dentist.

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

Because the amount of your Benefits is not conditioned on a Pre-Treatment Estimate decision by Delta Dental, all Claims under this Policy are post-service Claims.

Time of Payment of Claims: We will adjudicate each clean Claim within 45 days after receipt if the Claim is filed on paper, and 30 days after receipt if the Claim is filed electronically. If we fail to adjudicate a clean Claim in this time period, and we subsequently pay the Claim, we will pay interest on such Claim at the appropriate interest rate determined by applicable state law. If interest is due, the accrual will begin 31 days after the date the Claim is filed if it is an electronic Claim and 46 days after the date the Claim is filed if it is a paper Claim. Accrual of interest stops when the Claim is paid. As used here, a "clean Claim" means a Claim submitted by a Dentist for payment that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If a submitted Claim has deficiencies, we will notify the Dentist of such deficiencies not more than 45 days after receipt of the Claim if filed on paper, and 30 days if the Claim is filed electronically, with a description of any remedy necessary to establish a clean Claim. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the

Claim, and (d) inform you or your Dentist that the information must be received within 45 days or your Claim will be Denied if the services were performed by a Nonparticipating Dentist, or not chargeable to the patient if the services were performed by a Participating Dentist. You will receive a copy of any notice sent to your Dentist. Once Delta Dental receives the requested information, it has 15 days to adjudicate your Claim.

You may also appoint an authorized representative to deal with us on your behalf with respect to any Claim you file or any review of a Denied Claim you wish to pursue (see the Claims Appeal Procedure section). You should call Delta Dental's Customer Service department, toll-free, at [800-971-4108 (TTY users call 711)], or write them at [P.O. Box 1596, Indianapolis, Indiana 46206], to request a form to fill out designating the person you wish to appoint as your representative. Delta Dental will only recognize the person you have authorized on the last dated form filed with Delta Dental. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not inform you of the status of your Claim. You will have to get that information from your representative. If you have not designated a representative, Delta Dental will communicate with you directly.

If you have any questions about your Policy, please call Delta Dental's Customer Service department, toll-free, at [800-971-4108 (TTY users call 711)]. You may also write to Delta Dental's Customer Service department at [P.O. Box 1596, Indianapolis, Indiana 46206]. When writing to Delta Dental, please include your name, the Policy number, the Insured's ID number, and your date of birth and telephone number.

RENEWABLE - PREMIUM MAY CHANGE

CONDITIONALLY: You must keep this Policy in force by timely payment of the premiums. However, Delta Dental may refuse renewal due to:

- A. Non-payment of premiums subject to the Grace Period provision; or
- B. Fraud or material misrepresentation made by or with the knowledge of the Insured or an Eligible Dependent applying for this coverage or filing a Claim for Benefits;
- C. The Insured engaging in intentional and abusive noncompliance with material provisions of the Policy; or
- D. The company ceasing to renew all Policies issued on this form to residents of the state where you live.

Delta Dental may refuse renewal for reasons (A) through (D) above as of any premium due date.

At least 30 days' notice of any non-renewal action permitted by this clause will be mailed to you at

your last address as shown in Delta Dental's records. If Delta Dental fails to provide 30 days' notice of our intent to terminate coverage, your coverage will remain in effect until 30 days after notice is given or until the effective date of replacement coverage, whichever occurs first. However, no Benefits will be paid for expenses incurred during any period of time for which premium has not been paid.

TERMINATION: All insurance will cease on termination of the Policy. This Policy will terminate on:

- A. Non-payment of premiums when due, subject to the Grace Period provision;
- B. The date Delta Dental receives a written request from you to terminate the Policy or any later date stated in your request; or
- C. The date Delta Dental declines to renew the Policy provided by the above renewal clause; or
- D. Date of your death, if this Policy is an Individual Plan.

Delta Dental will refund any premium paid and not earned due to Policy termination. The refund will be based on the number of full months that remain in the premium period.

This Policy may be continued after your death: (a) by your Spouse, if a Dependent covered under this Policy; or otherwise, (b) by the youngest Child who is a Dependent covered under this Policy. The Policy will be changed to a plan appropriate, as determined by us, to the Dependents who continue to be covered under it. Your Spouse, or youngest Child, will replace you as the Insured. A proper adjustment will be made in the premium required for the Policy to be continued. Delta Dental will also refund any premium paid and not earned due to the Insured's death. The refund will be based on the number of full months that remain in the premium period.

Termination of Spouse's Coverage: The Insured's Spouse will cease to be a Dependent at the end of the premium period in which you become legally divorced.

Termination of a Child's Coverage: A Child will cease to be covered under this Policy at the time he or she ceases to meet the definition of Dependent.

Benefits After Coverage Terminates: Termination of coverage will be without prejudice to any Claim for Covered Services incurred prior to the date coverage terminates. Benefits for Covered Services incurred after a Dependent ceases to be insured are provided for certain procedures. No Benefits are provided, however, if the Policy is terminated because of: (a) a request by the Insured; (b) fraud or material misrepresentation on your part; or (c)

your failure to pay premiums. Certain procedures begun before the coverage terminates may be covered if the services were completed within a 30-day period measured from the date of termination. In those cases, Delta Dental will evaluate those services in progress to determine what portion may be paid by Delta Dental. The balance of the total fee is your responsibility.

GENERAL BENEFIT PROVISIONS

Types of Dental Benefits

The Benefits covered by this Policy are set forth in your Summary of Dental Plan Benefits. Delta Dental agrees to provide Benefits to Eligible Persons under the policies and procedures of Delta Dental, including the Processing Policies, and under the terms and conditions of this Policy, including, but not limited to, the exclusions and limitations set forth below.

EXCLUSIONS AND LIMITATIONS

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits, and all charges for these services will be the responsibility of the Insured:

1. Services for injuries or conditions payable under Workers' Compensation or Employer Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Medicaid or Medicare.
2. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
4. Services completed or appliances completed before a person became eligible under this Policy. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
5. Prescription drugs, except intramuscular injectable anesthetic(s), premedication, medicaments/solutions, and relative analgesia.
6. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
7. Charges for hospitalization, laboratory tests, histopathological examinations and miscellaneous tests.
8. Charges for failure to keep a scheduled visit with the Dentist.

9. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
10. Services or supplies, as determined by Delta Dental, that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
11. Services or supplies, as determined by Delta Dental, which are specialized techniques.
12. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the supervision of a licensed dentist. Treatment rendered by any other licensed dental professional may be covered only as solely determined by Delta Dental.
13. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
14. Services or supplies received due to an act of war, declared or undeclared, or terrorism.
15. Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
16. Services or supplies that are not within the categories of Benefits that have been selected and that are not covered under the terms of this Policy.
17. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
18. Interim caries arresting medicament.
19. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
20. Space maintainers for maintaining space due to premature loss of anterior primary teeth.
21. Sealants.
22. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
23. Veneers.
24. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
25. Prefabricated crowns used as final restorations on permanent teeth.
26. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting for people age 19 and over. If Orthodontic Services are Covered

Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the Policy.

27. Implant/abutment supported interim fixed denture for edentulous arch.
28. Soft occlusal guard appliances.
29. Paste-type root canal fillings on permanent teeth.
30. Replacement, repair, relines, or adjustments of occlusal guards.
31. Chemical curettage.
32. Services associated with overdentures.
33. Metal bases on removable prostheses.
34. The replacement of teeth beyond the normal complement of teeth.
35. Personalization or characterization of any service or appliance.
36. Temporary crowns used for temporization during crown or bridge fabrication.
37. Posterior bridges in conjunction with partial dentures in the same arch.
38. Precision attachments and stress breakers.
39. Implants and implant-related services for people age 18 and under.
40. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction, maxillofacial surgery, soft tissue grafting, guided tissue regeneration and periodontal or implant bone grafting.
41. Bone replacement and specialized implant surgical techniques, including radiographic/surgical implant imaging.
42. Appliances, restorations, or services for the diagnosis, treatment or disturbances of the temporomandibular joint (TMJ).
43. Orthodontic services.
44. Diagnostic radiographs and cephalometric films, unless done for Orthodontics and Orthodontics are a Covered Service.
45. Myofunctional therapy.
46. Mounted case analyses.
47. Any and all taxes applicable to the services.
48. Processing Policies may otherwise exclude payment by Delta Dental for services or supplies. [Please see the following website for a list of all exclusions: [www.xxxxxxx.xxx]]

Delta Dental will make no payment for the following services. Participating Dentists may not charge Members for these services or supplies.

All charges from Nonparticipating Dentists for the following services or supplies are your responsibility:

1. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
2. The completion of forms or submission of Claims.
3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluation.
4. Caries risk assessment performed on a Member age 2 or under.
5. Local anesthesia.
6. Acid etching, cement based cavity liners, and bases for temporary fillings.
7. Infection control.
8. Temporary, interim, or provisional crowns.
9. Gingivectomy done in conjunction with the placement of a restoration.
10. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
11. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
12. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
13. Post-operative X-rays, when done following any completed service or procedure.
14. Periodontal charting.
15. Pins and preformed posts, when done with core buildups.
16. Any substructure when done for inlays, onlays, and veneers.
17. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
18. A pulpotomy on a permanent tooth, except on a tooth with an open apex.

19. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
20. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
21. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
22. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
23. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.
24. Full mouth debridement when done within 30 days of scaling and root planing.
25. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
26. Scaling and debridement in the presence of inflammation or mucositis of a single implant when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planing, periodontal surgery or debridement of a periodontal defect.
27. Full mouth debridement when done on the same day as comprehensive evaluation.
28. A sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as a direct sealant repair, preventive resin restoration or interim caries arresting medicament performed on the same tooth.
29. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
30. Reline, rebase, or any adjustment or repair within six months of the delivery of a denture.
31. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
32. Periapical and/or bitewing X-rays when done within a clinically unreasonable period of time

of performing panoramic and/or full mouth X-rays, as determined solely by Delta Dental.

33. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
34. Processing Polices my otherwise exclude payment by Delta Dental for services or supplies. [Please see the following website for a list of all exclusions: www.xxxxxxx.xxx]

Limitations

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

1. Bitewing X-rays are payable once per calendar year, unless a full mouth X-ray which include bitewings has been paid in that same year.
2. Panoramic or full mouth X-rays (which may include bitewing X-rays) are payable once in any five-year period.
3. Any combination of teeth cleanings (prophylaxes, full mouth debridement, scaling in the presence of inflammation, and periodontal maintenance procedures) are payable twice per calendar year.
4. Full mouth debridement is payable once in a lifetime.
5. Oral examinations (not including limited problem focused evaluations or patient screenings) and evaluations are only payable twice per calendar year, regardless of the Dentist's specialty.
6. Patient screening is payable once per calendar year.
7. Preventive fluoride treatments are payable twice per calendar year for individuals age 18 and under.
8. Bilateral space maintainers are payable once per arch in a lifetime for people age 13 and under.
9. Unilateral space maintainers are payable once per quadrant in a lifetime for people age 13 and under.
10. A distal shoe space maintainer is payable for first permanent molars once per quadrant for people age 8 and under.
11. Cast restorations (including jackets, crowns, and onlays) and associated procedures (such

as core buildups and post substructures) are payable once in any five-year period per tooth.

12. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure).
13. Individual crowns over implants are payable at the prosthodontic benefit level once in a five year period.
14. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people age 11 and under.
15. Hard full or partial arch occlusal guards are payable once in a lifetime.
16. An interim partial denture is payable only for the replacement of permanent anterior teeth for individuals age 16 and under or during the healing period for individuals age 17 years and over.
17. Biologic materials to aid in soft and osseous tissue regeneration are payable once per natural tooth in a 36 month period.
18. Prosthodontic Services limitations:
 - a. One complete upper and one complete lower denture, and any implant used to support a denture, are payable once in a five-year period.
 - b. A removable partial denture, endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
 - c. A removable unilateral partial denture is payable once per quadrant in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
 - d. Fixed bridges and removable cast partial dentures are payable for people age 15 and under.
 - e. A relin or the complete replacement of denture base material is payable once in any three-year period per appliance.
 - f. Implant removal is payable once per lifetime per tooth or area.
 - g. Implant maintenance is payable once per any twelve (12) month period.
 - h. Removal of a broken implant retaining screw is payable once in a 5 year period.
19. Orthodontic Services limitations, if covered under the Policy pursuant to your Summary of Dental Plan Benefits:

- a. Orthodontic Services are payable for people pursuant to the age limits specified in your Summary of Dental Plan Benefits.
 - b. If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
 - c. Upon written notification to Delta Dental and to the patient, a Dentist may terminate treatment for lack of patient interest and cooperation. In these cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
 - d. An observation and adjustment is payable twice in a 12-month period.
20. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage as long as Delta Dental receives a Claim for those services within one year of the date of service.

When services in progress are interrupted, Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.

22. Care terminated due to the death of an Eligible Person will be paid to the limit of Delta Dental's liability for the services completed or in progress.
23. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment:

- a. Resin, porcelain fused to metal, and porcelain crowns (including implant crowns), bridge retainers, or pontics on posterior

teeth – Delta Dental will pay only the amount that it would pay for a full metal crown.

- b. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
- c. Resin, or porcelain/ceramic onlays on posterior teeth – Delta Dental will pay only the amount that it would pay for a metallic onlay.
- d. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.
- e. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.
- f. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
- g. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
- h. Posterior stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.

24. Maximum Payment:

All Benefits available under this plan are subject to the Maximum Payment limits set forth in your Summary of Dental Plan Benefits.

- 25. If a Deductible amount is stated in the Summary of Dental Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.
- 26. Caries risk assessments are payable once in any 36-month period for Members age 3-18. In the event a caries risk assessment is performed on a Member age 2 or under, such risk assessment will be treated as not chargeable to the patient.
- 27. Assessments of salivary flow by measurement are payable in any 36-month period.
- 28. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period.
- 29. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface.

- 30. Processing Policies may otherwise limit payment by Delta Dental for services or supplies. [Please see the following website for a list of all exclusions: [www.xxxxxxx.xxx]]

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

- 1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
- 2. Core buildups and other substructures are payable only when needed to support a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
- 3. Replacement of a crown, onlay, inlay, veneer, space maintainer or bridge within six months of the healing date is not a Covered Service.
- 4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
- 5. Root planing is payable once in any two-year period.
- 6. Periodontal surgery is payable once in any three-year period.
- 7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
- 8. Tissue conditioning is payable twice per arch in any three-year period.
- 9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
- 10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
- 11. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period when performed by the same office.
- 12. A sealant, sealant repair, preventive resin restoration or interim caries arresting

medicament is not payable when done on the same day as restorations involving the occlusal surface when performed by the same office.

13. A sealant, sealant repair or preventive resin restoration is not payable when performed within 24 months of a sealant, sealant repair or preventive resin restoration performed on the same tooth.
14. One caries risk assessment is allowed on the same date of service.
15. One caries risk assessment is allowed within a twelve (12) month period when done by the same Dentist/dental office.
16. One assessment of salivary flow by measurement is allowed within a twelve (12) month period when done by the same dentist/dental office.
17. Processing Policies may otherwise limit payment by Delta Dental for services or supplies. [Please see the following website for a list of all exclusions: [www.xxxxxxx.xxx]]

CLAIM PROVISIONS

Agreement

Delta Dental agrees to make payments for Covered Services provided to the Insured and Dependents described below and on the Summary of Dental Plan Benefits. The Plan that is chosen by the Insured and specified on the Summary of Dental Plan Benefits will determine how payment is made.

Payment of Claims

Your Summary of Dental Plan Benefits will indicate whether the Plan you have selected is Delta Dental PPO (Standard) or Delta Dental PPO (Point-of-Service) and will also set forth your applicable Coinsurance. Remember, your actual out-of-pocket cost may be more if you receive treatment from a Nonparticipating Dentist.

A. Delta Dental PPO (Standard):

Regardless of your Dentist's participating status, Delta Dental will base its payment on the lesser of the Submitted Amount or the Delta Dental PPO Dentist Schedule. Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Coinsurance, Copayments or Deductibles.

If your Dentist is not a Delta Dental PPO Dentist, but is a Delta Dental Premier Dentist, you will also be responsible for any difference between the Delta Dental PPO Dentist Schedule and the Delta Dental Premier Dentist Schedule for Covered Services, in addition to Coinsurance, Copayments or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for

most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

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

B. Delta Dental PPO (Point-of-Service):

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

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

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

If your Dentist is an Out-of-Country Dentist, Delta Dental will base payment on the Out-of-Country Dentist Fee for Covered Services.

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

Orthodontics

If this Policy includes coverage for orthodontics it will be identified on and paid as reflected in your Summary of Dental Plan Benefits.

Covered Services Requiring Multiple Visits

In the event a Covered Service requires more than one (1) visit with your Dentist, payment for the Covered Service will be rendered upon the Completion Date.

Reconsideration and Claims Appeal Procedure

Reconsideration

Delta Dental will notify you or your authorized representative if you receive an Adverse Benefit

Determination after your Claim is filed. An Adverse Benefit Determination is any Denial, reduction, or termination of the Benefit for which you filed a

Claim, or a failure to provide or to make payment (in whole or in part) of the Benefit you sought (“Adverse Benefit Determination”).

This includes any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which Benefits are otherwise provided was experimental or investigational or was not medically necessary or appropriate.

If Delta Dental informs you that the Policy will pay the Benefit you sought but will not pay the total amount of expenses incurred, and you must make a payment to satisfy the balance, you may also treat that as an Adverse Benefit Determination.

If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly Denied all or part of your Claim, you or your Dentist may contact Delta Dental’s Customer Service department at their toll-free number, [(800) 971-4108 (TTY users call 711)], and ask them to reconsider the Claim to make sure it was processed correctly. You may also mail your inquiry to the Customer Service department at [P.O. Box 1596, Indianapolis, Indiana 46206].

When writing, please enclose a copy of your Explanation of Benefits and describe the problem. Be sure to include your name, your telephone number, the date, and any information you would like considered about your Claim.

A request for reconsideration is not required and should not be considered a formal review. It is a review of a Denied Claim. Delta Dental provides this opportunity for you to describe problems and submit information that might indicate that your Claim was improperly Denied and allow Delta Dental to correct this error quickly.

Whether or not you have asked Delta Dental informally, as described above, to reconsider our initial determination, you can submit your Claim to a formal review through the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure

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

To request a formal review of your Claim, send your request in writing to:

**Dental Director
Delta Dental Plan of Michigan, Inc.
[P.O. Box 30416
Lansing, MI 48909-7916]**

Please include your name and address, the Insured’s ID number, the reason you believe your Claim was wrongly Denied, any other information you believe supports your Claim, and indicate in your letter that you are requesting a formal appeal of your Claim. You also have the right to review any documents related to the Policy. If you would like a record of your request and proof that Delta Dental received it, you should mail it certified mail, return receipt requested.

The Dental Director or any person reviewing your Claim will not be the same person, nor subordinate to, the person(s) who initially decided your Claim. The reviewer will grant no deference to the prior decision about your Claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the Claim for the first time. The reviewer’s decision will take into account all documents, records and other information relating to your Claim, even if the information was not available when your Claim was initially decided.

If the decision is based in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person’s subordinate consulted during the initial determination.

The reviewer will make a determination within 30 days of receipt of your request. If your Claim is Denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Your notice of an Adverse Benefit Determination will inform you of the specific reason(s) for the Denial, the pertinent Policy provision(s) on which the Denial is based, the applicable review procedures for dental Claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your Claim free of charge. This notice will also contain a description of any additional materials necessary to complete your Claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your Claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will

include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge. The Adverse Benefit Determination notice will inform you of your right to a managerial-level conference to complete the formal grievance procedure.

COORDINATION OF BENEFITS

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

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

Definitions

Plan

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

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

policies; or coverage under other federal governmental plans, unless permitted by law.

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

This Plan

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

Order of Benefit Determination Rules

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

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

Allowable Expense

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

The following are examples of expenses that are not Allowable Expenses:

1. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement

amount for a specific benefit is not an Allowable Expense.

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

Closed Panel Plan

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

Custodial Parent

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

Order of Benefits Determination Rules

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

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

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Not Dependent or Dependent. The plan that covers the Person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the plan that covers the person as a dependent is the Secondary Plan. However, if the Person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

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

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

- ◆ If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

However, if one spouse's Plan has some other coordination rule (for example, a "gender rule" which says the father's Plan is always primary), we will follow the rules of that Plan.

- b. For a dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:
- ◆ If a court decree states that one of the parents is responsible for the dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - ◆ If a court decree states that both parents are responsible for the dependent Child's health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits;
 - ◆ If a court decree states that the parents have joint custody with one specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (a) above shall determine the order of benefits; or
 - ◆ If there is no court decree allocating responsibility for the dependent Child's health care expenses or health care coverage, the order of benefits for the child will be as follows:
 - (1) The Plan covering the Custodial Parent;
 - (2) The Plan covering the spouse of the Custodial Parent;
 - (3) The Plan covering the non-custodial parent; and then
 - (4) The Plan covering the spouse of the non-custodial parent.
- c. For a dependent Child covered under more than one Plan of individuals who are not the parents of the Child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Child.

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

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

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

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

Effect on the Benefits of This Plan

When This Plan is secondary, it may reduce its Benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary

Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, Benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

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

Facility of Payment

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

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

Right of Recovery

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

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. You or your Dentist should contact Delta Dental's Customer Service department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-870-9988, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 4833-9089. You may also follow the Claims Appeal Procedure below. If you are still not satisfied, you may contact the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 800-466-1526, or visit the Department's website at <http://www.insurance.ohio.gov>.

GENERAL PROVISIONS

- A. **Entire Contract; Changes:** This Policy, which shall include the Summary of Dental Plan Benefits, constitutes the entire contract between the parties hereto. No change in this Policy will be effective until approved by an officer of Delta Dental. This approval must be printed on or attached to this Policy. No agent may change this Policy or waive any of its provisions.
- B. **Two Year Limit on Certain Defenses:** A material misstatement by you in any application for this Policy may be used to void this Policy or to Deny a Claim. This action may be taken in the first two years of a person's coverage. After the two-year period, this action may be taken only for a fraudulent misstatement and non-payment of premium.
- C. **Legal Actions:** No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy, unless prohibited by applicable state law. No such action may be brought after the expiration of three years from the time written proof of loss is required to be given.
- D. **Change of Beneficiary:** Unless you make an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Policy or to any change of beneficiary or beneficiaries, or to any other changes in this Policy.
- E. **Conformity With State Laws:** Any part of the Policy in conflict with the laws of the state where you live on the Policy's Effective Date is changed to conform to the minimum requirements of that state's laws.

- F. **Change of Status:** You must notify Delta Dental of any event that changes the status of a Dependent. Events that can affect the status of a Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.
- G. **Assignment:** Services and/or benefit payments are for the personal benefit of you and your Dependents and cannot be transferred or assigned, other than to the extent necessary to allow direct payments to Participating Dentists.
- H. **Right of Recovery:** If Delta Dental pays a Claim for which another person or company is liable, Delta Dental has the right to recover its payment from the other person or company.
- I. **Obtaining and Releasing Information:** While you are covered by Delta Dental, you agree to provide Delta Dental with any information it needs to process your Claims and administer your Benefits. This includes allowing Delta Dental to have access to your dental records.
- J. **Dentist-Patient Relationship:** Individuals are free to choose any Dentist. Each Dentist maintains the dentist-patient relationship with the patient and is solely responsible to the patient for dental advice and treatment and any resulting liability.
- K. **Right of Recovery Due to Fraud:** If Delta Dental pays for dental services that were sought or received under fraud, that is, false, or misleading pretenses or circumstances, or pays a Claim that contains false or misrepresented information, or pays a Claim that is determined to be fraudulent due to the acts of you and/or your Dependent, it may recover that payment from you and/or your Dependent. You and your Dependent authorize Delta Dental to recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you and/or your Dependent. Delta Dental will provide an explanation of the payment being recovered at the time the deduction is made.

PREMIUMS

- A. **Premium Payment:** Each premium is to be paid on or before its due date. A due date is the last day of the period for which the preceding premium was paid. Premium is to be paid annually. Delta Dental will also accept monthly premiums only when paid by credit card or automatic withdrawal, or when paid with our prior consent. Each premium is to be paid at the administrator's office.

From time to time, Delta Dental may change the rate tables used for this Policy form. Each

premium will be based on the rate table in effect on that premium's due date. The Policy plan, age of Insured, length of time the Policy has been in force, and place of residence on the premium due date are factors used in determining premium rates. Delta Dental will make no change in your premium solely because of Claims made under this Policy. At least 30 days' notice of any rate change as permitted by this clause, will be mailed to you at your last address as shown in our records.

- B. **Grace Period:** This Policy has a 31-day grace period (the "Grace Period"). This means that if a premium, other than the initial premium, is not paid by the date it is due, it may be paid during the following 31 days. The Policy will remain in force during this Grace Period. The Grace Period will not apply if, at least 30 days before the due date, Delta Dental has delivered or mailed to your last known address a written notice of our intent not to renew this Policy.

Reinstatement: If you do not pay the premium by the end of the Grace Period, your Policy will lapse. This Policy may be reinstated, but Delta Dental may require an application. You must pay the premium to Delta Dental.

If an application is not required, your Policy will be reinstated when the premium is accepted. If an application is required, and a conditional receipt is issued, your Policy will be reinstated when the application is approved by Delta Dental. If the application is disapproved, your Policy will not be reinstated. If the application is received by Delta Dental, but is neither disapproved in writing nor approved, your Policy will be reinstated 45 days after the date of the conditional receipt.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than 60 days before the date of reinstatement.

The reinstated Policy will cover only loss that results from an injury sustained after the date of reinstatement or sickness that starts more than ten days after such date.

A change may be made in your Policy in connection with the reinstatement. These changes will be sent to you for you to attach to your Policy. In all other respects, you and Delta Dental will have the same rights as before your Policy lapsed.

- D. **Misstatement of Age:** If you or your Dependent's age has been misstated, the Benefits may be adjusted, based on the relationship of the premium paid to the

premium that should have been paid, based on the correct age.

Inquiries
Delta Dental
Attention: Customer Service
[P.O. Box 1596
Indianapolis, Indiana, 46206]
Customer Service: [800-971-4108 (TTY users call 711)]

SAMPLE

**Notice Concerning Coverage
Limitations and Exclusions under the Ohio Life
and Health Insurance Guaranty Association
Act**

Residents of Ohio who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The value of the extra protection provided by these insurers through the guaranty association is not limited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continuing residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer for which you have assumed the risk, such as a variable contract sold as a product. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. However, *insurance companies and their agents are prohibited by law from using the name of the guaranty association to induce you to purchase any kind of insurance policy.*

Ohio Life and Health Insurance Guaranty Association
5005 Horizons Drive, Suite 200
Columbus, OH 43220

Ohio Department of Insurance
50 West Town Street
Third Floor-Suite 300
Columbus, OH 43215

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract; if they are insured under a group insurance contract, issued by a member insurer; or if they are the payee or beneficiary of a structured settlement annuity contract. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar organization in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does **not** provide coverage for:

- any policy or portion of a policy which is not owned by the insured or of which the individual has assumed the risk, such as a variable contract sold to prospective investors;
- any policy of reinsurance (unless an assumption certificate has been issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured, the association will pay a maximum of \$300,000, except as specified below, no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. The association will not pay more than \$100,000 in cash surrender value, \$500,000 in major medical insurance benefits, \$300,000 in disability or long-term care insurance benefits, \$100,000 in other health insurance benefits, \$500,000 in present value of annuities, or \$300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages, the association will pay a maximum of \$300,000 for coverage involving major medical insurance benefits, for which the maximum of all coverages is \$500,000.

Note for plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under §§401, 403(b) or 457 of the Internal Revenue Code, the limit is \$250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than \$300,000 in the aggregate per individual, except as noted above. For covered unallocated annuities that fund other plans, a special limit of \$1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

FACTS **WHAT DOES DELTA DENTAL DO WITH YOUR PERSONAL INFORMATION?**

Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	<p>The types of personal information we collect and share depend on the product or service you have with us. This information can include:</p> <ul style="list-style-type: none"> ▪ Social Security Number and Insurance claim information ▪ Transaction history and Medical information ▪ Credit card payments and Employment information <p>When you are <i>no longer</i> our customer, we continue to share your information as described in this notice.</p>
Why?	All financial companies need to share members' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their members' personal information; the reasons Delta Dental chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Delta Dental share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to your orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	We do not share
For our affiliates' everyday business purposes – information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We do not share
For nonaffiliated companies to market to you	No	We do not share

For More Concerns: Call 517-347-5451 (TTY users call 711). All other questions must be answered by calling your general customer service number.

Who we are	
Who is providing this notice?	Delta Dental Plan of Michigan, Inc.; Delta Dental Plan of Ohio, Inc.; Delta Dental Plan of Indiana, Inc.; Delta Dental of North Carolina; and Delta Dental Plan of New Mexico, Inc.

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What we do	
How does Delta Dental protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.
How does Delta Dental collect my personal information?	We collect your personal information, for example: <ul style="list-style-type: none"> ▪ When you apply for insurance ▪ When you file an insurance claim ▪ When you give us your contact information ▪ When you use your credit or debit card ▪ When we pay your insurance claim
Why can't I limit all sharing?	Federal law gives you the right to limit only: <ul style="list-style-type: none"> ▪ Sharing for affiliates' everyday business purposes — information about your creditworthiness ▪ Affiliates from using your information to market to you ▪ Sharing to non-affiliated companies to market to you State law and individual company policies may give you additional rights to limit sharing.
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. <p><i>Our affiliates include companies with the Delta Dental name in Michigan, Ohio, Indiana, Kentucky, Tennessee, New Mexico, Arkansas and North Carolina; insurance companies such as Renaissance Life & Health Insurance Company of America and Renaissance Life & Health Insurance Company of New York.</i></p>
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. <ul style="list-style-type: none"> ▪ <i>Delta Dental does not share your personal information with nonaffiliates so they can market to you.</i>
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. <ul style="list-style-type: none"> ▪ <i>Delta Dental does not jointly market with nonaffiliated financial companies.</i>
Other important information	
<p>For residents in AZ, CA, CT, GA, IL, ME, MA, MN, MT, NV, NJ, NC, OH, OR and VA: To review your personal information, write to Privacy Officer, 4100 Okemos Road, Okemos, MI 48864. You must state your full name, address, policy number (if applicable) and the information you would like to see. We will tell you what information we have, and you may review and copy it at our office or ask that we mail a copy to you for a fee. If you think that personal information that we have about you is wrong, you may write to us. We will tell you what actions we take because of your letter. If you do not agree with our actions, you may send us a statement.</p>	

