

SCHEDULE OF BENEFITS
for
Eastern Kentucky University
High Option

P600

Your Certificate of Coverage outlines all benefit plan options. This Schedule of Benefits tells you exactly which of those benefits are covered under **your** plan. The payment of benefits is subject to the exclusions, limitations, and other terms of your Certificate.

Dependent Age Limit:	Up to 26 Years of Age.
Benefit Period:	Calendar Year
Waiting Period:	None.
Orthodontic Eligibility:	Dependents to age 19.

DEDUCTIBLE

<u>Network</u>	<u>Out-of-Network</u>
\$0	\$0

BENEFIT MAXIMUMS

<u>Network</u>	<u>Out-of-Network</u>
\$2,000 per Covered Person each Benefit Period.	\$2,000 per Covered Person each Benefit Period.
\$1,000 lifetime maximum for Orthodontic Services.	\$1,000 lifetime maximum for Orthodontic Services.

AMOUNT

Network

Diagnostic and Preventive Services are payable at 100% of the Allowable Amount.

Minor Services (Class I, II, & III) are payable at 85% of the Allowable Amount.

Major Services (Class IV) are payable at 60% of the Allowable Amount.

Orthodontic Services are payable at 50% of the Allowable Amount.

Out-of-Network

Diagnostic and Preventive Services are payable at 100% of the Allowable Amount.

Minor Services (Class I, II, & III) are payable at 85% of the Allowable Amount.

Major Services (Class IV) are payable at 60% of the Allowable Amount.

Orthodontic Services are payable at 50% of the Allowable Amount.



Delta Dental PPO Plus Premier

Certificate of Coverage Benefit Booklet

HOW TO HAVE A WARM SMILE

Your teeth are meant to last a lifetime, and by following the tips below, they normally will. We know you want to make sure your teeth remain healthy and strong for the rest of your life.

- Plaque is a major culprit in gum disease. To help prevent gum disease, brush regularly, use a fluoride tooth paste and floss at least once a day.
- To help prevent oral cancer avoid tobacco in any form - cigarettes, pipes, cigars, and smokeless tobacco.
- See your dentist at least once a year for an oral exam - even if you don't have your natural teeth.
- Never put your baby to bed with a bottle containing milk, formula, fruit juice or any other sweetened liquid. This can damage your baby's teeth.
- Be sure you brush and floss your child's teeth at least once a day, preferably right before bedtime.

All it takes is a couple of conscientious, daily habits to prevent dental diseases. Make these tips part of a healthy lifestyle that includes proper nutrition, exercise and stress management. The few minutes you spend each day properly caring for your teeth and gums are valuable investments in a healthy, happy, and warm smile.

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HOW TO USE YOUR CERTIFICATE AND SCHEDULE OF BENEFITS

The Certificate gives you a general description of all dental benefit plan options. The Schedule of Benefits, included with the Certificate, tells you exactly which of those benefits are covered under your plan. The Certificate and Schedule of Benefits are not a legal contract. The Group Contract is the legal contract; the Certificate and Schedule of Benefits are subject to its terms and conditions. In the event of conflict, the provisions of the Group Contract will prevail over the Certificate and Schedule of Benefits.

1. SCHEDULE OF BENEFITS

The Schedule of Benefits explains the amount of benefits payable for Covered Services under your plan. It also tells you the amount of any Deductibles, Co-payments, and maximums under your Certificate.

2. DEFINITIONS

This section defines terms having special meanings. A word or phrase starting with a capital letter has a special meaning. It is defined either in the Definitions section, in the text, or is a title.

3. DENTAL BENEFITS

This section explains the dental benefits we provide for Covered Services under all dental benefit options. See your Schedule of Benefits for the amount of benefits payable for Covered Services under your plan.

4. EXCLUSIONS

This section lists some of the services for which benefits are not provided. You should read this section carefully. We want to be sure that you do not expect benefits that are not included in your Certificate.

5. GENERAL PROVISIONS

This section explains general terms. It tells you such things as how to get benefits; how benefits are paid; your relationship with Dentists; your relationship with us; and how and when your coverage stops.

6. RIDERS

A Rider may be added to the Certificate. It changes provisions or benefits in the Certificate.

Many of the questions you might have about your dental benefits can be answered by reading your Certificate and your Schedule of Benefits. If you are unable to answer a question, contact your group administrator or call or write to us.

DEFINITIONS

This section defines terms having special meanings. Whenever you see a word or phrase that starts with a capital letter, it is a title or has a special meaning. It is defined in this section or at the place where it is used.

1. **ALLOWABLE AMOUNT** means the maximum amount of payment for Covered Services based on the applicable reimbursement schedules. Network Providers agree to accept the Allowable Amount as payment in full. It may not be the amount that is charged to you.
2. **ALTERNATE RECIPIENT** means any child of a Member who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under the Group Contract with regard to such Member.
3. **BENEFIT PERIOD** means the calendar year, unless a different time is shown in the Schedule of Benefits. The Benefit Period is the time that we pay benefits for Covered Services. If your coverage ends earlier, the Benefit Period ends at the same time.
4. **CERTIFICATE** means this summary of the terms of your dental benefits. It is a summary of the Group Contract and is subject to the Group Contract.
5. **CO-INSURANCE** means the percentage of the Allowable Amount for a Covered Service that you must pay.
6. **COMPANY** means Delta Dental of Kentucky, Inc. It is usually referred to as “we,” “us” or “our.”
7. **COVERED PERSON** means the Member or any covered Dependents and is sometimes referred to as “you” or “your.”
8. **COVERED SERVICE** means a service or supply shown in your Certificate for which benefits will be paid. The Covered Service must be rendered by a Dentist. A charge for a Covered Service will be considered to be incurred:
 - A. For an appliance, or modification of an appliance - on the date the appliance is placed;
 - B. For a crown, bridge or gold restoration - on the date the crown or bridge is seated;
 - C. For root canal therapy - on the date the root canal is completed; or
 - D. For all other services - on the date the service is rendered.
9. **DEDUCTIBLE** means an amount shown in the Schedule of Benefits that you must pay for Covered Services before we start to pay.
10. **DENTALLY NECESSARY (OR DENTAL NECESSITY)** means a service or supply that is required to identify or treat your condition, disease or injury. The service or supply must be provided by a Dentist. The fact that a Dentist prescribes or approves a service or supply or a court orders service or supply to be rendered does not make it Dentally Necessary. We must determine that the service or supply is:
 - A. Consistent with the symptoms, diagnosis or treatment of the condition, disease or injury;
 - B. Consistent with standards of good dental practice;
 - C. Not solely for the convenience of you or your Dentist;
 - D. The most appropriate supply or level of service that can safely be provided to you.
11. **DENTIST** means any dentist licensed under Chapter 313 of the Kentucky Revised Statutes or similar law in other states. Dentists licensed out of the Commonwealth of Kentucky must be licensed in accordance with laws comparable to the laws of the Commonwealth of Kentucky.
12. **DEPENDENT** means either:
 - A. The Member’s lawful spouse; or
 - B. Any of your children who satisfy the conditions below. “Children” includes newborn children, stepchildren, children legally placed for adoption and legally adopted children.

Children are eligible for coverage only after they become your Dependents. To obtain coverage for these children, we may require that you complete a dependency affidavit and provide us with a copy of any legal documents awarding guardianship of such children to you or your spouse.

To be classified as a Dependent child, a child must:

- be less than the age limit in the Schedule of Benefits; and
- never have been married.

A child legally placed with the Member for adoption is eligible for coverage from the date that the Member assumes and retains a legal obligation for support of such child in anticipation of the adoption of such child. The child's eligibility terminates upon the Member's termination of such legal obligation.

If the Schedule of Benefits provides benefits for full-time students, "full-time students" are Dependents enrolled in a state-accredited college, university, trade or secondary school on a full-time basis.

Eligibility will continue past the age limit for Dependents who are totally disabled and who are Covered Persons upon reaching the age limit. The Dependent must have been totally disabled before reaching the age limit. A physician must certify that the Dependent is totally disabled. We may require proof of the disability from time to time. A total disability is a condition that results when any physical handicap or mental retardation prevents a Dependent from engaging in substantial gainful activity. The disability must be expected to result in death or be continuous or of indefinite duration. We are the final authority for determining whether a Dependent is totally disabled.

Coverage Effective Dates and enrollment requirements are described in your Group Contract.

13. **EFFECTIVE DATE** means the date when your coverage begins with us.
14. **GROUP** means the employer, trust, or other plan sponsor that has entered into a Group Contract with us.
15. **GROUP CONTRACT** means the contract issued to the Group to provide certain benefits for your dental care expenses.
16. **INVESTIGATIONAL** means a drug, device, supply, treatment, procedure, facility, equipment or service that is being studied to determine if it should be used for patient care or if it is effective. Something that is Investigational is not recognized as effective dental practice. We reserve the sole right to determine what is Investigational. Approval by the Food and Drug Administration (FDA) does not mean that we approve the service or supply. Drugs classified as Treatment Investigation New Drugs by the FDA are Investigational. Devices with the FDA Investigational Device Exemption and any services involved in clinical trials are Investigational.
17. **MEMBER** means an employee or member of the Group who has applied for coverage under the Group Contract, has met our underwriting guidelines, and whose name appears on the identification card issued by us.
18. **NETWORK PROVIDER** means any Dentist which has agreed to participate in the DeltaPreferred Option and DeltaPremier Programs. Network Providers have agreed not to bill you except for the amount of any Co-insurance, Deductibles or non-covered services. Member co-insurance is generally less through the DeltaPreferred Option Network.
19. **OUT OF NETWORK PROVIDER** means any Dentist which has not agreed to participate in the DeltaPreferred Option and DeltaPremier Programs. Out of Network Providers may bill you for the balance of their charges in excess of our Allowable Amount as well as any Co-insurance, Deductibles and non-covered services.
20. **PAYROLL DEDUCTION-EMPLOYEE PAID CONTRACT** means the contract issued to your employer or dental plan sponsor which allows us to offer you certain benefit plans. Generally, this contract is different from the Group Contract for the following reasons: no contributions are made by your employer; your participation is voluntary; and the employer's sole function, without endorsing the plan, is to permit us to publicize the plan and collect premiums.
21. **QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)** refers to a court order which establishes the right of an Alternate Recipient to receive benefits for which a Covered Person is eligible under the Group Contract. The QMCSO must clearly specify: the name and mailing address of the Member as well as the name and mailing address of each Alternate Recipient covered by the order; a reasonable description of the type of coverage to be provided; and the period covered by the court order.

22. **TREATMENT PLAN** means a written report prepared by a Dentist. It shows the recommended course of treatment for any dental disease, defect, or injury. The Treatment Plan must be based on an examination made by a Dentist while coverage under this Certificate is in effect. We must approve the Treatment Plan before services are provided to you. We may use specialist consultants, patient examination, or other review procedures either pre-operative or post-operative to assure that appropriate treatment has been recommended and/or performed by the Dentist. If a complete Treatment Plan is not submitted prior to services being rendered, we may decrease the amount of benefits or benefits may be denied in total. Our approval will be subject to the benefit limits of your coverage and our internal benefit guidelines and policies.

DENTAL BENEFITS

We will provide benefits for the following services and supplies, subject to the exclusions, limitations and other terms and conditions of this Certificate. The services and supplies must be Dentally Necessary. The amount of benefits is listed in the Schedule of Benefits. Certain services must be pre-approved by us before the services are Covered Services. Services, supplies or treatment not specifically listed are not covered. **Please note:** If you use a Network Provider, benefits are usually reimbursed at a higher percentage. **IMPORTANT:** This section outlines all coverage options. To see what benefits are actually covered under your plan, you must refer to the Schedule of Benefits included with this Certificate.

I. DIAGNOSTIC AND PREVENTIVE SERVICES

- A. Oral examination, including Treatment Plan.
- B. Emergency examination.
- C. Palliative emergency treatment.
- D. Periapical x-rays.
- E. Bitewing x-rays.
- F. Extraoral x-rays.
- G. Occlusal x-rays.
- H. Panoramic or complete series x-ray.
- I. Topical fluoride application.
- J. Prophylaxis, including cleaning and polishing.
- K. Space maintainers - a Treatment Plan must be submitted and approved by us.
- L. Sealants.

LIMITATIONS FOR DIAGNOSTIC AND PREVENTIVE SERVICES

- Benefits for an oral examination are limited to one examination in a six month period. In the event a Treatment Plan is subsequently submitted, benefits are limited to the Allowable Amount for the oral examination.
- Benefits are not provided for periapical x-rays when performed on the same date as a complete series or a panorex.
- When the total amount charged for individual periapical x-rays equals or exceeds the Allowable Amount for a complete series, benefits are limited to the Allowable Amount for a complete series. Benefits will also be subject to the limitations for a complete series.
- Benefits for bitewing x-rays are limited to one set in a twelve month period.
- Benefits for either panoramic or complete series x-rays are limited to one panoramic or complete series x-ray in a 36 month period.
- No benefits will be provided for a sialography.
- Benefits for topical fluoride application are limited to one application per Benefit Period and for Covered Persons less than 19 years of age.
- Benefits for a prophylaxis are limited to one prophylaxis in a 6 month period.
- No benefits will be provided for preventive control programs, including, but not limited to oral hygiene instruction, dietary control and training in preventive care.
- Space maintainers are a benefit for Dependents less than 12 years of age.
- No benefits will be provided for replacement, repair or adjustments to space maintainers.
- Sealant Benefits are limited to topically applied acrylic plastic or composite material used to seal developmental grooves and pits on the occlusal surface only in teeth for the purpose of preventing dental decay.

1. Benefits for sealants are limited to dependents less than 14 years of age.
2. Benefits for sealants include the application of sealants to permanent molar teeth. The occlusal surface must be intact. The entire tooth must be free of caries (decay) with no restorations.
3. Benefits for sealants are limited to one sealant application per tooth in a three year period.
4. Benefits for sealants will not be provided for:
 - any sealant repair or replacement made less than three years after a sealant placement or replacement which was covered under this Certificate;
 - any sealant placed on a deciduous tooth;
 - any sealant placed on other than the occlusal surface;
 - sealants placed for any reason other than the prevention of dental decay.
5. Repair or replacement of a sealant which was covered under this Certificate is considered part of a completed procedure and is not a separate benefit.

II. CLASS I SERVICES

- A. Fillings consisting of silver amalgam, silicate, and plastic restorations.
- B. Stainless Steel Crowns.
- C. Simple extractions.
- D. Oral Surgery consisting of surgical extractions, fractures, dislocation treatment, treatment of cysts and tumors.
- E. Apicoectomy.
- F. Root canal therapy.
- G. General anesthesia.

LIMITATIONS FOR G.

- Benefits for general anesthesia are limited to the following covered oral surgical procedures and allowed only when administered by a dentist properly licensed to administer general anesthesia:
 - 7230 - Removal of impacted tooth - partially bony
 - 7240 - Removal of impacted tooth - completely bony
 - 7241 - Removal of impacted tooth - completely bony, with unusual surgical complications
 - 7250 - Surgical Removal of residual root
 - 7260 - Oroantral fistula closure
 - 7350 - Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment, and management of hypertrophied and hyper plastic tissue);

or,

five or more simple extractions performed on the same date of service.
- General anesthesia is not a covered benefit when performed in conjunction with procedures relating to Restorative or Endodontics Services when administered for the sole purpose of patient management.
- General anesthesia is defined as a drug-induced depression of the central nervous system that renders the patient unconscious and insensible to pain.

LIMITATIONS FOR CLASS I SERVICES

- Benefits for amalgam and resin restorations will be allowed only once per tooth surface in a 24 month interval.
- Benefits are provided for one restoration in each tooth surface in an episode of treatment.

- Benefits for composite resin or acrylic restorations in posterior teeth are limited to the Allowable Amount for an amalgam restoration.
- Benefits are provided for stainless steel crowns when placed on primary teeth.
- Benefits are not provided for pulp capping except for exposure or near exposure of the pulp.
- Benefits for direct and indirect pulp caps performed on the same day as the final restoration are limited to the Allowable Amount for a single complete restorative procedure.
- Routine postoperative procedures are considered part of the total surgical procedure.
- Dry socket treatments are considered part of a complete procedure and are not a separate benefit.
- Sutures performed in conjunction with extractions are considered part of a complete procedure and are not a separate benefit.
- No benefits will be provided for services or supplies for a sequestrectomy.
- Benefits are not provided for a separate charge for periapical x-rays, cultures, follow-up care, treatments, pulpotomy or pulpectomy, or routine postoperative procedures that are components of a root canal. Benefits are limited to the Allowable Amount for a root canal.
- Remineralization (recalcification) includes the temporary restoration. Benefits for permanent restorations are allowable only after two (2) months have elapsed following placement of the temporary restoration.

III. CLASS II SERVICES (Refer to the Schedule of Benefits included with this Certificate to see if these services are Covered Services, and/or if there are additional exclusions for these services under your plan.)

Periodontal services are those that treat the inflammation of the supporting or surrounding structure of the teeth (periodontitis) which includes comprehensive therapy. Your Dentist must submit a written Treatment Plan to us for these services and we must approve the Treatment Plan before your Dentist performs the services in order for you to obtain benefits. Our approval will be subject to the benefit limits of your coverage and our internal benefit guidelines and policies.

You and your Dentist are responsible for agreeing to a complete treatment and maintenance program. If you fail to follow the maintenance program, you will not be eligible for benefits for the services rendered for retreatment.

A. Periodontic Benefits are limited to:

1. Periodontal maintenance prophylaxis;
2. Gingival curettage;
3. Periodontal scaling and root planing;
4. Gingivectomy or gingivoplasty;
5. Gingival flap procedure;
6. Mucogingival surgery;
7. Osseous surgery to include flap entry and closure;
8. Bone replacement grafts (excluding the use of synthetic bone); and
9. Occlusal guards.

LIMITATIONS FOR CLASS II SERVICES

- Benefits for periodontal scaling and root planing, periodontal maintenance prophylaxis and gingival curettage, when performed on the same day as a prophylaxis, are limited to the Allowable Amount for one procedure.
- Benefits for a periodontal maintenance prophylaxis for the first twelve months following periodontal therapy are limited to one periodontal maintenance prophylaxis in a 3 month period. Thereafter, a periodontal maintenance prophylaxis is limited to once in a six month period.
- Benefits for a periodontal maintenance prophylaxis are not a benefit unless the patient has completed active periodontal therapy.

- Benefits for a periodontal scaling and root planing (per quadrant), when performed pre-surgical, are available when the procedure is completed within 3 months of active therapy. Once completed, benefits are limited to one periodontal scaling and root planing (per quadrant) in a 24 month period.
- Benefits for a gingival curettage are limited to one gingival curettage in a 24 month period.
- Benefits for osseous surgery and/or osseous grafts are not a benefit when performed within 24 months of a surgical curettage.
- Benefits are provided for occlusal guards when the patient has had periodontal therapy or is in an approved maintenance program.
- Benefits for occlusal guards will not be provided for:
 - an occlusal guard for children with primary or mixed dentition;
 - an occlusal guard for any reason other than the prevention of bruxism;
 - repair or relining.
- Benefits for an occlusal guard are limited to one occlusal guard in a five year period.
- General anesthesia is not a covered benefit when performed in conjunction with procedures relating to Periodontic Services when administered for the sole purpose of patient management.
- See your Schedule of Benefits for Plan specific limitations.

IV. CLASS III SERVICES (Refer to the Schedule of Benefits included with this Certificate to see if these services are Covered Services, and/or if there are additional exclusions for these services under your plan.)

A. Simple repairs to complete or partial dentures are limited to:

1. Adjustments;
2. Repair broken denture base;
3. Replace missing or broken teeth;
4. Repair or replace broken clasp; and
5. Replace broken teeth.

LIMITATIONS FOR CLASS III SERVICES

- Benefits are not provided for special techniques or personalized restorations in connection with a bridge or denture. Benefits are limited to the Allowable Amount for a standard procedure.
- The maximum benefit for repair of a full or partial denture is 50% of our Allowable Amount for replacement of the full or partial denture.

V. CLASS IV SERVICES (Refer to the Schedule of Benefits included with this Certificate to see if these services are Covered Services, and/or if there are additional exclusions for these services under your plan.)

Your Dentist must submit a Treatment Plan to us for the following services. We must approve the Treatment Plan before the Dentist performs the services.

- A. Inlays;
- B. Crowns.
- C. Prosthetic Services are limited to:
 1. Dentures, full and partial;

2. Bridges, fixed - a Treatment Plan must be submitted and approved by us prior to services being rendered;
3. Repairs involving adding teeth or clasps;
4. Denture reline or rebase;
5. Bridge repair; and
6. Tissue conditioning.

LIMITATIONS FOR CLASS IV SERVICES

- Benefits for either an inlay or crown are limited to one inlay or crown in a five year period.
- Benefits for porcelain veneer or cast crowns for a Dependent are not provided until the Dependent is 12 years of age. If approved by us, benefits are provided for an acrylic crown or preformed crown for Dependents under 12 years of age.
- Benefits for any optional gold restoration, crown or jacket, are limited to the Allowable Amount for an amalgam, synthetic or plastic restoration for treatment of caries.
- Facings posterior to the first molar are considered cosmetic dentistry. Benefits are limited to the Allowable Amount for a cast full crown.
- Benefits for Prosthetics will not be provided for:
 - any denture or bridge replacement made less than five years after a denture or bridge placement or replacement which was covered under this Certificate; or
 - any denture replacement made necessary by reason of loss or theft.
- Benefits are not provided for special techniques or personalized restorations in connection with a bridge or denture. Benefits are limited to the Allowable Amount for a standard procedure.
- No benefits will be provided for services or supplies for implants.
- Benefits for services and supplies in connection with an overdenture, including, but not limited to crowns and root canal treatment are limited to the Allowable Amount for a full denture.
- Benefits for denture reline or rebases are limited to one reline or rebase in a 36 month period and at least six months after initial placement.
- The maximum benefit for repair of a full or partial denture is 50% of our Allowable Amount for replacement of the full or partial denture.
- Benefits for tissue conditioning are limited to three times in an episode of treatment.
- Benefits are not provided for fixed bridges or removable cast partials for Dependents under age 16.
- A posterior bridge in conjunction with a partial denture in the same arch is considered optional. If performed, the benefits are limited to the Allowable Amount for a partial denture.
- Benefits are provided for stayplates to replace only extracted anterior permanent teeth during the healing period for children 16 years of age or under. The amount of benefits for this service will be deducted from the amount of benefits provided for the permanent appliance. The Covered Person must pay the difference in cost.
- General anesthesia is not a covered benefit when performed in conjunction with procedures relating to Prosthetic Services when administered for the sole purpose of patient management.
- See your Schedule of Benefits for Plan specific limitations.

VI. ORTHODONTIC SERVICES (Refer to the Schedule of Benefits included with this Certificate to see if these services are Covered Services, and/or if there are additional exclusions for these services under your plan.)

Orthodontic Services for handicapping malocclusion includes the initial and subsequent installation of orthodontic appliances. A handicapping malocclusion is defined as the malalignment of teeth and/or jaws which significantly interferes with their function. Orthodontic Services also include all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and its attendant sequelae through the correction of malposed teeth. We will provide benefits for Orthodontic Services. The payment of benefits is subject to the conditions and limitations listed below and in your Certificate.

1. When using a Network Provider your coverage pays 50% of the Allowable Amount for Covered Services. The Deductible does not apply.

When using an Out of Network Provider your coverage pays 40% of the Allowable Amount for Covered Services. Covered Services are subject to the Deductible listed in your Schedule of Benefits.

2. The diagnosis of Orthodontic Services must show that the handicapping malocclusion is abnormal and can be corrected. A Treatment Plan must be submitted to us. We must approve the Treatment Plan before your Dentist performs the Orthodontic Services.
3. We may review your dental records to decide if benefits will be provided for the requested services.
4. All Orthodontic Services are deemed to have been rendered on the date performed.
5. Orthodontic Services are limited to:
 - A. One diagnosis and treatment plan including initial exam, x-rays, models and photographs in a 5 year period;
 - B. Minor treatment for tooth guidance;
 - C. Minor treatment to control harmful habits;
 - D. Interceptive orthodontic treatment;
 - E. Comprehensive orthodontic treatment;
 - F. Treatment of the atypical or extended skeletal case;
 - G. Post-treatment stabilization.

LIMITATIONS FOR ORTHODONTIC SERVICES

- Treatment, including necessary appliances may not exceed a maximum of 36 months. The maximum number of months for which benefits are provided for treatment will be reduced by the number of months of such treatment received before the commencement of coverage under this Certificate.
- If the Orthodontic Services are terminated before completion of the approved Treatment Plan, no benefits will be provided after the month of termination.
- No benefits will be provided for charges for the replacement and/or repair of any appliance furnished under the Treatment Plan.
- Benefits are provided for Orthodontic Services after the Treatment Plan has been completed under certain circumstances. At least five years must have passed from the date the previous treatment was completed and the lifetime benefit maximum has not been reached.
- General anesthesia is not a covered benefit when performed in conjunction with procedures relating to Orthodontic Services when administered for the sole purpose of patient management.
- See your Schedule of Benefits for Plan specific limitations.

GENERAL EXCLUSIONS AND LIMITATIONS

In addition to coverage limitations within each benefit section, no benefits will be provided for the following services or supplies, regardless of Dental Necessity:

1. Services or supplies for the diagnosis and treatment of temporomandibular joint syndrome/dysfunction/surgery, by, among other things, intra-oral prosthetic devices such as, but not limited to, biteguards, splints, orthopedic splints, and mandibular repositioning devices, or by any other method to alter vertical dimension, and treatment of temporomandibular joint dysfunction regardless of medical or Dental Necessity including, but not limited to, myofascial pain dysfunction, masticatory myofascial pain dysfunction, craniomandibular disorder and stomatorhabydomyostis;
2. Services or supplies received from a dental or medical department maintained by or on behalf of the Group, a mutual benefit association, labor union, trustee, or similar person or group;
3. Services and supplies for which you have no legal obligation to pay in the absence of this or similar coverage, or for which no charge has been made;
4. Services or supplies for any condition, disease, defect, ailment or accidental injury arising out of and in the course of employment if benefits or compensation are available under any Workers' Compensation Act or other similar law. This applies if you receive the benefits in whole or in part. It also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from a third party;
5. Procedures, appliances or restorations that are primarily to alter, restore or maintain occlusion. If performed, it should be done with the agreement of the patient to assume additional cost. These include:
 - A. Services to alter or restore vertical dimension;
 - B. Services to restore occlusion;
 - C. Services to replace tooth structure lost by attrition, abrasion, and/or erosion;
 - D. Services to correct congenital malformation;
 - E. Services for esthetic purposes;
 - F. Services for gnathological purposes;
 - G. Services for equilibration purposes; and
 - H. Services for periodontal splinting;
6. Benefits are not provided for services or supplies that are not Dentally Necessary. The fact that a Dentist prescribes or approves a service or supply, or that a court orders a service or supply to be obtained does not make it Dentally Necessary. We are the final authority for determining if services or supplies are Dentally Necessary. No benefits are provided for services, supplies or treatments not specifically listed as a Covered Service. Some coverage limitations and exclusions are in the relevant benefit section;
7. Services or supplies to the extent that benefits are available from or provided by any other group coverage. We will coordinate the payment of benefits with any other coverage where permissible under applicable laws;
8. Services and supplies that are Investigational;
9. Services and supplies for any state or federal hospital, except facilities for the uniformed services;
10. Benefits are not provided for services and supplies for any military-connected disability or condition;
11. Services and supplies for which the Covered Person is eligible or for which benefits are available under any governmental health plans (except Medicaid), although we will coordinate the payment of benefits under the Certificate with such other governmental health plans to the extent required under existing state and federal laws and regulations;
12. Services, supplies or other care provided in treatment of injuries sustained or illnesses resulting from participation in a riot or civil disturbance; or while committing or attempting to commit an assault or felony. Services, supplies or other care required while incarcerated in a federal state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs;
13. Services and supplies for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;
14. Services or supplies rendered before the effective date of the Group Contract or after the termination date of the Group Contract; or services or supplies rendered before your Effective Date or after your termination date;

15. Specialized techniques, including, but not limited to, precision attachments, implantology, over-dentures, and procedures associated therewith, personalization or characterization;
16. Prescription drugs, premedications, injections;
17. Charges for hospitalization, including hospital visits;
18. Mounted case-analysis;
19. Laboratory tests and/or examinations;
20. Bleaching;
21. Consultations;
22. Orthodontics (Refer to the Schedule of Benefits included with this Certificate to see if these services are Covered Services, and/or if there are additional exclusions for these services under your plan.);
23. Services and supplies for cosmetic purposes and complications resulting from such services;
24. In the event you transfer from the care of one Dentist to another Dentist during your course of treatment, benefits are limited to the Allowable Amount for services of one Dentist;
25. In the event more than one Dentist performs services for one procedure, benefits are limited to the Allowable Amount for the services of one Dentist;
26. In all cases in which there are optional techniques or treatment, benefits are limited to the Allowable Amount for the least expensive treatment, unless we determine that the more expensive procedure is Dentally Necessary;
27. Complete occlusal adjustment;
28. Services provided by an anesthesiologist;
29. A separate allowance is not provided for tooth preparation, temporary services, bases, impressions, local anesthesia or other services that are components of a complete procedure;
30. Restorative services, including, but not limited to, restorative crowns, inlays/onlays, are benefits only when performed due to fracture or decay;
31. No benefits are provided for services and supplies that do not meet our dental or benefit policy guidelines;
32. Services or supplies not specifically listed in the Certificate.

GENERAL PROVISIONS

This Certificate of Coverage, your enrollment form, and our Group or Payroll Deduction-Employee Paid Contract with your employer or dental plan sponsor, including any amendments thereto, constitute the entire contract among the parties. This Certificate of Coverage is issued to Members who are covered by means of a Payroll Deduction-Employee Paid Contract as well as Members who are covered by means of a Group Contract. Sections of this Certificate of Coverage dealing with Coordination of Benefits (COB) and COBRA do not apply if you are covered by means of a Payroll Deduction-Employee Paid Contract as defined in the Definitions Section. Generally, COBRA and COB in this Certificate only apply if you are covered by means of a Group Contract. Even if your employer does not pay any portion of your premium you may be covered by means of a Group Contract. If you have any questions regarding whether or not you have a Payroll Deduction-Employee Paid or Group dental plan, please ask your employer or dental plan sponsor. This Certificate replaces all other Contracts and Certificates, if any, we have issued to you, your employer, or dental plan sponsor.

AMENDMENTS

- A. We may amend your Certificate or adjust the premiums from time to time. We will inform the Group in writing 30 days before the amendment goes into effect.
- B. The benefits will be provided only for Covered Services you receive after your Effective Date and before the date your coverage terminates.
- C. Benefits will be provided only for Covered Services prescribed by, performed by or under the direction of a Dentist.

COVERED PERSON/DENTIST RELATIONS

- A. Delta Dental contracts with certain Dentists, called "Participating Dentists," in an attempt to reduce dental care costs. We are not liable for any act or omission of any Dentist. This Certificate does not give anyone any claim, right or cause of action based on what any provider of dental care or supplies does or does not do.
- B. You may select any Dentist or other Professional Provider. We do not recommend any Dentist or other Professional Provider. A Dentist or other Professional Provider may decline to provide care to you.
- C. The difference between a Network Provider and an Out of Network Provider is defined in the Definition Section.

CONTRACT ADMINISTRATION

- A. No change in this Certificate will be effective until approved by an officer of the Company. No agent or representative of the Company, other than an officer, may change this Certificate or waive any of its provisions.
- B. Administrative policies and procedures used by us in interpreting your Certificate are binding upon you as if they were included in your Certificate.
- C. In order for us to correctly process claims and as a condition to our agreement to provide benefits to you, you agree that any and all dental records, including x-rays, involving any condition for which a claim is presented, will be furnished to us upon our request. All privileges relating to such information are waived. Benefits will not be provided where sufficient information cannot be obtained to properly process your claim.
- D. We sometimes request certain information to make a decision on claims involving services or supplies. You agree any person or entity having information about an illness, injury or condition for which benefits are claimed, may give us any information about the illness, injury or condition. You agree that we may give any person or entity any information about an illness, injury or condition, (at it's request) if it is providing similar benefits. You also agree that we may provide necessary information to your Group or the Group's representative, as requested by the Group. You agree that you will, upon request, execute consent forms in connection with the release of this information as requested by the Group or the Company.
- E. We may obtain one or more advisory opinions from another Dentist(s) before making our decision on claims. Also, we may refer certain cases to an appropriate dental review committee or other professional for an opinion before we make our final decision on such claims.
- F. We may request a Dentist to physically examine any Covered Person with respect to the Covered Services provided under this Certificate. We will choose the Dentist and pay for his or her services.

- G. The Company, or anyone acting in our behalf, shall determine the administration of contract benefits in such a manner that has a rational relationship to the terms set forth herein. However, the Company, or anyone acting in our behalf, has complete discretion to determine the administration of contract benefits. This includes without limitation, determinations on whether services, care, treatment, or supplies are Dentally Necessary, Investigational, whether surgery is cosmetic surgery, or whether charges are reasonable. Such a determination shall be final and conclusive. However, a Covered Person may utilize all applicable grievance procedures.
- H. The Company, or anyone acting in our behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of the Certificate. This includes, without limitation, the power to construe the contract, to determine all questions arising under the Certificate, and to make, establish and amend the rules and regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate. However, these powers shall be exercised in such a manner that has a reasonable relationship to the provisions of the Contract and Certificate. A specific limitation or exclusion will override a more general benefit language.

PAYMENT OF BENEFITS

- A. We are authorized to make payments directly to Network Providers providing Covered Services. We may make such payments to and send notice regarding the receipt and/or adjudication of claims to an Alternate Recipient or that person's custodial parent or designated representative. We may make such payments directly to you. Any payments made by us will discharge our obligation to pay for Covered Services. To receive payment of benefits, all claims must be filed during the Benefit Period in which services are performed or within 12 months following that Benefit Period.
- B. In the event of death, all benefits owed to a Covered Person will be paid to the Covered Person's estate. If there is no estate, we reserve the right to make payment to a relative by blood or by marriage appearing to be equitably entitled to payment.
- C. Payments for Covered Services to Network Providers are considered payment in full. The Network Provider may bill you only for the amounts equal to Deductibles, Co-Insurance, or non-covered charges.
- D. Out of Network Providers may bill you for any Deductibles, Co-Insurance or non-covered charges as well as any balance between the amount charged and the amount paid by us.
- E. You shall not assign the benefits or the rights to the benefits for Covered Services under this Certificate.
- F. The Covered Person cannot request us not to pay any claims for Covered Services submitted by a Dentist. We will have no liability to any person because of our rejection of the request.
- G. We may accidentally pay claims that do not come within the specific benefit provisions of your Certificate. Such payment shall not be considered as a precedent in the disposition of similar cases in the future.
- H. You must notify us within 30 days of any change in your family or membership status, such as a birth, a child ceasing to be a Dependent, a divorce or a death.

FILING A CLAIM FOR BENEFITS

- A. When you (or a covered member of your family) receive Covered Services, a claim must be filed with us. Note: To be eligible for payment, notice of any claims must be submitted in writing to Dental Choice of Kentucky, Inc. during the Benefit Period in which services are performed, or within 12 months following that Benefit Period.
- B. A Network Provider will file claims for you. If an Out of Network Provider will not file your claim, claim forms and assistance in completing them are available from our customer service representatives at the number below.
- C. You may combine several bills on one claim form, but you must submit a separate claim form for each family member.
- D. When you submit a claim form, you must attach itemized bills for the Covered Services. The bill must show the following:
- the name and address of the dentist;
 - the full name of the patient; and
 - the date, type of service, and charge for each service.

- E. These bills will not be returned to you, so if you want to keep personal copies of your bills, be sure to make the copies before you submit the bills to us. Mail the form and the itemized bills to:

Dental Dental of Kentucky, Inc.
P.O. Box 242810
Louisville, Kentucky 40224-2810

For prompt answers to your questions contact our customer service representatives at (800) 955-2030.

COORDINATION OF BENEFITS

- A. Benefits paid to you or on your behalf are coordinated with any other group dental plan under which you are covered. Benefits are limited in all cases to a maximum of 100 percent of the total amount for Covered Services.
- B. In processing a claim where two or more group dental plans exist, the primary-secondary payment rule determines how benefits are provided. It is applied in the following manner:
1. If another plan does not contain a provision in its contract on coordination of benefits similar to this provision, the other plan will be primarily responsible for claims incurred by the patient. The benefits provided under this Certificate will be reduced to the extent necessary so that the sum of the reduced benefits and the benefits payable by the other plan do not exceed the total amount for such Covered Services;
 2. The benefits of a plan which covers the patient as other than a Dependent, i.e., as a Member, will be payable before the benefits of a plan which covers the patient as a Dependent;
 3. The benefits of a plan which covers the patient as a Dependent of the parent whose birthday falls earlier in the year will be payable before the benefits of the plan which covers the patient as a Dependent of the parent whose birthday falls later in the year. If both parents have the same birthday, the benefits of the plan which has covered the parent longer will be payable before the benefits of the plan of the parent for the shorter period of time. However, if the other plan does not follow the birthday rule specified in this paragraph, but instead uses an order of benefit determination based on gender, and, as a result, the plans do not agree on an order of benefits, then the other plan's order of benefit determination will determine coverage. In the case of a claim on a patient who is a Dependent child:
 - a. If the parents are separated or divorced and the parent with custody has not remarried, the plan covering the parent with custody has primary responsibility for the claim over the plan covering the parent without custody;
 - b. If the parents are divorced and the parent with custody has remarried, the plan covering the custodial parent has primary responsibility over the plan covering the stepparent with custody. Further, the plan covering the stepparent with custody of the child has primary responsibility over the plan covering the parent without custody; and
 - c. If there is a court decree establishing which parent is to be financially responsible for the child's dental care expenses, the plan covering the parent with financial responsibility has primary responsibility over any other plan covering the Dependent child. In this instance, (a) and (b) above would not apply.
- C. If you are insured under two group dental plans and the primary-secondary payment rule does not determine the order of payment, the plan which has covered you for the longer period of time is the primary plan, except that:
1. The benefits of the plan which has covered the patient as a retired or laid-off employee, or as the Dependent of such employee, will be payable after the benefits of the plan which has covered the patient as an employee other than as a retired or laid-off employee, or as the Dependent of such employee, i.e., as an active employee; and
 2. If either plan does not contain a coordination provision with respect to retired or laid-off employees, resulting in each plan paying its benefits after the other, then the provisions of (1) above will not apply.

SUBROGATION

- A. You agree that we shall be subrogated, and succeed to any of your interest or rights against any other person or entity. We will have first priority in the payment. You also agree that we can exercise our right to direct recovery against you.
- B. You shall assist us in our Subrogation efforts. Some of the ways in which you will assist us is by executing necessary documents. You will not take any action prejudicing our rights or interests. We may suspend the payment of claims under your Group Contract in the event you fail to cooperate with our efforts.
- C. We may exercise our rights under this section to the extent of the total amount of benefits paid by us.

TERMINATION OF YOUR COVERAGE

- A. Your Certificate will be renewed for consecutive periods of coverage upon our receipt of payment for your premiums. This renewal is subject to our right to cancel or decline renewal of your Certificate. It is also subject to the Group's right to terminate the Group's contract. Benefits will not be paid for services incurred after your date of termination.
- B. If your premiums are not paid to us within 30 days of the date they are due, your Certificate will be terminated as of the date through which premiums have been paid. No benefits will be provided for services incurred by you after the date of termination.
- C. Benefits may be denied and coverage terminated if it is found that your application contains misrepresentations which caused us to issue your Certificate to you when we would not have ordinarily done so. Benefits may be denied if any claim you file contains misrepresentations which caused us to pay benefits when we would not have ordinarily done so. Any termination of coverage will be effective as of the date the misrepresented information was received.
- D. Benefits will cease for a Covered Spouse:
- on the date of divorce;
 - upon termination of the Member's coverage; or
 - on the date the Member no longer carries the spouse as a Covered Dependent.
- E. Benefits will cease for a Dependent child:
- when the child no longer meets the definition of a Dependent;
 - on the date the Member no longer carries the child as a Covered Dependent.
- F. You have the right to make changes, subject to any eligibility and underwriting guidelines, only at the Group's annual reopening period.
- G. Your coverage, if it has been terminated in any manner, may be reinstated by us, in our sole discretion, upon such terms and conditions as we determine.
- H. If your coverage has terminated under the provisions of this Certificate, you will be entitled to extend coverage for the purpose of the completion of any approved Treatment Plan if you receive Covered Services within 30 days from the date of the approval and the approval was issued prior to your termination date.

CONTINUATION OF GROUP COVERAGE UNDER FEDERAL LAW (COBRA)

- A. If COBRA applies to the Group, any Member whose coverage under this Certificate has been terminated due to:
1. termination of employment (unless because of gross misconduct),
 2. reduction in the number of hours worked, or
 3. the elimination of coverage, in whole or substantially in part, within one year before or after the commencement of bankruptcy by or against the Group from whose employment the Member had retired at any time,
- is entitled to continue his or her existing Group benefits at 102 percent of the then applicable Group rate.
- B. Continuation of Group coverage is available to covered spouses and children who lose coverage due to:

1. the death of the Member;
2. divorce from the Member; or
3. the covered child's loss of dependency status.

Continuation of Group coverage is also available to children born to, or placed for adoption with, the Member during a period of Continuation of Group Coverage.

C. Continuation of dental coverage alone is available only if dental coverage is available independent of health and/or vision coverage to similarly situated beneficiaries who have not experienced a qualifying event.

D. Continuation of Group coverage will terminate on the earlier of:

1. 18 months from the date the Covered Person's coverage otherwise would have terminated under this Certificate because of the Member's termination of employment or reduction in hours worked;
2. 36 months from the date a Covered Person's coverage would otherwise have terminated under this Certificate because of the Member's death, divorce, or the Dependent child ceasing to be a Dependent child;
3. Death, for a retired Member continuing benefits due to the Group's bankruptcy, and 36 additional months for a Covered Person who is surviving spouse;
4. The date the Covered Person is covered by other group coverage. If the other group coverage excludes or limits benefits for a pre-existing condition, this provision does not apply;
5. 29 months from the date of the qualifying event if the Covered Person is disabled under Title II or XVI of the Social Security Act at the time coverage under this Certificate ended, or becomes disabled at any time during the first 60 days of Continuation of Group Coverage. One hundred and fifty percent of the applicable premium may be charged for the last 11 months thereof;
6. The date through which the Covered Person has timely paid the group premium; or
7. The date this Group Contract is terminated. If the Group has other group Dental coverage, the Covered Person may be eligible to continue benefits under the other dental coverage.

E. In order to obtain COBRA coverage under this contract, the Group must:

1. Notify all Covered Persons of their right to continue group coverage as required by federal law;
2. Notify us as soon as possible of a qualifying event and of the selection by a Covered Person of continued group coverage and of the effective date of COBRA coverage;
3. Collect and forward premiums to us on a timely basis; and
4. In order to obtain this coverage for COBRA continuees enrolled with the Group prior to beginning coverage under this Certificate, the Group must provide all information requested by the Company regarding COBRA continuees at the same time the Group application is made. In order to obtain this coverage for COBRA continuees acquired as a result of an acquisition or merger, the Group must provide this information to the Company prior to the effective date of the acquisition or merger.

F. In order to obtain COBRA coverage under the contract, the Covered Person must:

1. Notify and provide documentation to the Group within 60 days of:
 - a. a separation or divorce from the spouse;
 - b. the birth or adoption of a child;
 - c. a change in a Dependent child's dependency status; or
 - d. a Social Security disability determination;
2. Request in writing to continue the Group coverage within 60 days after notice of that right has been given by the Group; and
3. Pay the first applicable premium to the Group within 45 days of the election date, and pay the remaining premiums within 30 days of the due date.

RIGHT OF RECOVERY

Whenever any payment for Covered Services has been made by us in an amount that exceeds the maximum benefits available for services under your Certificate, or whenever payment has been made in error by us, we have the right to recover such payment from you or, if applicable, the Dentist. As an alternative, we reserve the right to deduct from any pending or future claim any amounts you may owe us.

PREMIUM REFUND

Our responsibility to refund unused premiums, for any cause whatsoever, is limited to refunding the premium during a period starting with the latest renewal date or rate change, or maximum of 12 months, whichever is less.

TIME OF PAYMENT OF CLAIMS

We shall pay benefits for any Covered Services promptly upon receipt of written proof of loss, subject to a determination of the eligibility of such services for payment.

FAMILY AND MEDICAL LEAVE ACT OF 1993

If the Family and Medical Leave Act applies to the Member:

- A. A Covered Person who otherwise would be ineligible due to a Member's inactivity at work will retain eligibility during a period of leave under the Family and Medical Leave Act of 1993 (the Act). Membership may continue, at the Member's discretion for the period of leave under the Act;
- B. If the Member does not retain coverage during the leave period, the Member and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work. To obtain coverage for a former Member upon return from leave under the act, the Group must provide evidence satisfactory to the Company documenting the applicability of the Act to the Member.

CLAIMS APPEAL PROCEDURE

We will notify you, in writing, if a claim is denied in whole or in part. It will be forwarded to you within 30 days after the completed claim is received, unless circumstances require an extension of time to act on a claim. Additional periods of 45 days may be taken by us to evaluate your claim for an initial determination. We will notify you of the additional time period. The notice will explain why benefits were denied. It will also describe the Claims Appeal Procedure. You may appeal, in writing, the denial within 60 days of the date the notice of the claim denial is received by you. The appeal must state all the reasons why the claim should be paid. The appeal will be decided within 60 days of receipt for review, unless circumstances require a longer time. After review of the appeal, we will notify you of the decision concerning the appeal.

LIMITATION OF ACTIONS

No lawsuit may be filed by you to recover benefits on a claim submitted under your Certificate unless it is filed within 12 months from the date your claim was originally denied.

APPLICABLE LAW

Your Certificate is governed by and construed in accordance with the laws of the Commonwealth of Kentucky and any applicable federal laws.



DELTA DENTAL OF KENTUCKY, INC.
P.O. BOX 242810
LOUISVILLE, KY. 40224-2810
(800) 955-2030
www.deltadentalky.com

AMENDMENT TO CERTIFICATE

Under **MINOR SERVICES**, point A is deleted and replaced with the following:

- A. Fillings consisting of silver amalgam, plastic restorations, and composite resin.

Under **LIMITATIONS FOR MINOR SERVICES**, the third bullet point is deleted in its entirety.