OKLAHOMA COUNTY

Dental Care Certificate

ABOUT YOUR PLAN

This Dental Care Certificate is issued to the Subscriber by Delta Dental Plan of Oklahoma, Inc., sometimes referred to as DDPOK, an Oklahoma nonprofit dental service corporation, with its main office in Oklahoma City, Oklahoma. It is intended to be an easy to read outline of the principal features of your dental expense benefits plan provided by your employer, who has final authority and responsibility for the dental expense benefits plan. Certain administrative services are provided by Delta Dental Plan of Oklahoma. This Certificate, with any inserts, constitutes your summary of the plan and is subject to and superseded by the provisions of any applicable agreement between Delta Dental Plan of Oklahoma and Oklahoma County.

If any state or federal legislation is in effect, enacted, or amended requiring a change in the dental expense benefits described in this Certificate, appropriate modification may be made in the benefits provided under the plan.

Eligibility and Enrollment

To be eligible for enrollment in this plan, you, the Subscriber, must be an active full-time employee or a retired employee who was an active full-time employee at the time of your retirement, and be enrolled in the Oklahoma County group medical plan. "Full-time employee" means an employee who regularly works at least the number of hours in the normal work week set by your employer (but not less than 40 hours) at your employer's place of business or such other place or places as required by your employer. New-hire employees become eligible for enrollment the first of the month following 60 days of continuous, full-time employment.

To be eligible for dependent coverage under the group dental plan, dependents must be enrolled in the Oklahoma County group medical plan. The Subscriber is eligible for dependent coverage on the later of the date he/she becomes eligible for coverage or the date he/she first acquires an eligible dependent.

Eligible dependents include: (1) the spouse to whom the Subscriber is legally married; (2) biological children of the Subscriber; and (3) children of the subscriber by legal adoption or placement for adoption, guardianship, marriage (stepchildren), and foster care placement (foster child).

A dependent child, as defined above, is eligible for coverage until 11:59:59 p.m. (CT) of the last day of the month in which such dependent child attains the age of 26. An unmarried dependent child age 26 or over who is incapable of self-support due to a physical or mental incapacity can continue to be covered under this plan as a dependent, provided he or she is chiefly dependent on the Subscriber for support and a physician's certificate is received by DDPOK within six (6) months of said incapacity, the effective date of the Plan Agreement, the effective date of said dependent child's coverage, or the date on which said dependent child's coverage would otherwise terminate due to said dependent child attaining the maximum age for dependent children coverage, whichever is later.

Enrollment in the group dental plan is automatic when a Subscriber enrolls in the Oklahoma County group medical plan. If a Subscriber enrolls eligible dependents in the Oklahoma County group medical plan, those dependents will be automatically enrolled in the group dental plan.

Your plan benefits may be affected if you have two or more dental plans in effect at the same time. The Plan will coordinate these benefits as described herein to ensure maximum coverage for the patient. See "**Coordination of Benefits**" in this Certificate for more detail.

A person cannot be enrolled in this plan as both a Subscriber and a dependent of another Subscriber.

Disqualification, Ineligibility, and Forfeiture

Eligible Subscribers or dependents who fail to enroll in the plan within 31 days of their initial eligibility or who waive coverage at the time of their enrollment eligibility, or any enrolled person who voluntarily discontinues coverage, may request to enroll in the plan. Requests for enrollment after the end of the 31-day period following initial eligibility are subject to approval of the Plan Administrator.

Subscriber Amendments or Termination

Each Subscriber can apply to change from single coverage to family coverage if Plan Administrator receives the appropriate form requesting such change within 31 days of the Subscriber acquiring any eligible dependents. If a Subscriber has family coverage, newly-acquired eligible dependents can be added if Plan Administrator receives the appropriate form requesting such change within 31 days of the Subscriber acquiring the new eligible dependent. Evidence of insurability is not required if the Subscriber submits the written application within the 31-day period after the dependent is acquired. The effective date of coverage for such dependent(s) shall be the first of the month following the Plan Administrator's approval of the completed application.

A newborn dependent child will be covered from the date of birth if the Subscriber submits a written request and a "Change in Family Status" form to the Plan Administrator within the 31 days immediately following such child's date of birth and such form meets the approval of the Plan Administrator.

If the Subscriber's written request to add an eligible dependent is received later than the 31-day period following the Subscriber's acquiring such dependent or after a previous termination of coverage, the Subscriber must complete a "Service Request and Beneficiary Change/Group Evidence of Insurability" form, provided by the Plan Administrator, before the dependent can become covered. The Subscriber shall also be required to submit a "Change in Family Status" form, which must meet the approval of the Plan Administrator. If such evidence is satisfactory, the dependent shall become covered the first of the month following the date the application is approved.

If a dependent (other than a covered newborn of a participant with dependent coverage) is disabled on the effective date of his/her coverage under the Plan, so as to be unable to perform substantially all of the normal activities of a person of like sex and age in good health, the effective date for that dependent will be deferred until a period of at least 31 consecutive days has passed or when satisfactory evidence of good health is approved.

A Subscriber can apply to terminate coverage for one or more dependents provided one of the following conditions exists or has occurred:

- Dependent no longer meets the definition of eligible dependent, as set forth in the Plan Agreement
- Death of the dependent
- Divorce of the dependent and the subscriber
- Dependent enters military service
- Dependent acquires coverage elsewhere
- Plan anniversary date

The change will be effective the first of the month following the Plan Administrator's receipt and approval of the completed application.

A Subscriber or eligible dependent whose coverage under the Plan Agreement is terminated for any reason may be eligible to enroll in an individual direct payment contract with DDPOK if such person is a resident of the state of Oklahoma.

Employer Amendments or Termination

It is anticipated this plan will be continued indefinitely, but the employer reserves the right to change or terminate this plan in the future by agreement between the employer and DDPOK.

Coverage under this Certificate may be automatically terminated:

- On the last day of the month in which the Subscriber is permanently terminated from full-time service to the employer or becomes ineligible for benefits under the plan;
- On the last day of the month in which an enrolled Dependent ceases to be an eligible Dependent; or,
- On the last day of the month for which Subscriber contributions have been made should the Subscriber fail to make payment as required, if applicable; or
- On the date this plan is terminated or canceled.

Continuation of Coverage
For possible continuation of your group dental plan, see your employer's Human Resources Department regarding the provisions of COBRA. Subscribers, Dependents, and Beneficiaries can obtain a copy of the continuation of coverage procedures, without charge, from your employer or representative of your group.

A Subscriber or eligible dependent whose coverage under the Plan Agreement is terminated for any reason may be eligible to enroll in an individual direct payment contract with DDPOK if such person is a resident of the state of Oklahoma.

Qualified Medical Child Support Order (QMCSO)
If the Plan Administrator receives a court order to provide medical and/or dental coverage for a qualified Subscriber's dependent child, the Plan Administrator must notify the Subscriber and determine if the child is eligible for coverage under this group plan. Eligibility determinations will be made in accordance with federal and/or state child support order laws and regulations. The Subscriber will be responsible for any contributions required under this plan.

The coverage provided in accordance with a qualified medical child support order will be effective as of the date of the child support order and subject to all provisions of the plan except:

- a qualified dependent may be covered without personal coverage in effect under the group plan;
- in addition to the reasons for termination of coverage shown in the termination of coverage provisions herein, the coverage required by a qualified medical child support order will cease on the earlier of the date the support order expires or the date the dependent is enrolled for similar coverage.

Under this provision, if covered expenses for a dependent child are paid by a custodial parent or legal guardian who is not a plan member, benefits payable will be remitted directly to the custodial parent or legal guardian rather than the plan member or eligible Subscriber. A custodial parent or legal guardian may also sign the claim form and assign plan benefits, if assignable.

Any child of a plan participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to dependent coverage under this plan, with no pre-existing conditions provisions applied.

Qualified Domestic Relations Order (QDRO)
In the event of a Subscriber, Dependent, or Beneficiary receiving a Qualified Domestic Relations Order (QDRO), the Subscriber, Dependent, or Beneficiary must obtain a copy of the Medical Support Notice form, supplied by either DDPOK or the employer's Human Resources Department. This Notice form, with a copy of the Order, must be mailed to the Plan Administrator. The Plan Administrator shall take the necessary steps to ensure compliance with said QDRO. Subscribers, Dependents, or Beneficiaries can obtain a copy of the QDRO procedures, without charge, from the Plan Administrator.

DDPOK Termination
Coverage under this Certificate may be automatically terminated:

- On the last day of the month in which the Subscriber is permanently terminated from full-time service to the employer or becomes ineligible for benefits under the plan;
- On the last day of the month in which an enrolled Dependent ceases to be an eligible Dependent; or,
- On the last day of the month for which the last payment has been made if the Plan Administrator fails to make payment as required under the Plan Agreement; or,
- On the date on which the Plan Agreement is terminated or canceled.

Summary of Dental Plan Benefits
Your "Summary of Dental Plan Benefits" is included in this Certificate and shows the covered services included in your dental program. It also indicates the amount of your deductible and to which types of services the deductible applies.

After you satisfy any dental deductible required, your dental benefits will pay a specific amount of the cost of covered services, up to your benefits plan maximum for each benefit period. You will be responsible for the remaining co-payment amount, if any, and any charges that are not covered. *For your benefit maximum(s) and co-payment amounts, refer to your "Summary of Dental Plan Benefits" included in this Certificate.*

Your dental benefits are provided according to a benefit period, which begins initially on the date your coverage becomes effective under the Plan. A new benefit period (Plan Benefit Year) begins each year on January 1.

Benefits for some services are subject to certain limitations, such as age of patient, frequency of procedure, etc., and benefits may not be available under certain circumstances. ***Refer to your "Summary of Dental Plan Benefits" included in this Certificate for a comprehensive, but not all-inclusive, list of limitations and exclusions that apply to your dental plan.***

HOW TO USE YOUR PLAN

Delta Dental Network of Participating Dentists

You may visit the properly licensed dentist of your choice, because your plan provides for in-network as well as limited out-of-network benefit coverage. However, Delta Dental Plan of Oklahoma uses two nationwide networks of dentists—the Delta Dental Premier network and the Delta Dental PPO network—through Delta Dental Plan of Oklahoma's membership in a nationwide system known as Delta Dental Plans Association. These networks are among the largest in the dental benefits industry, both locally and nationwide, providing you easy access to participating dentists in most geographical areas.

Delta Dental Plans have unique "participating agreements" with those dentists in the networks described above. In most cases, these agreements mean you simply present your identification card to the dentist at the time of treatment and he or she will file your claim for you. Delta Dental Plan of Oklahoma will pay the participating dentist direct for any covered services.

Benefit Payment Procedure, Participating Dentists

Under the Delta Dental Plans participating agreements with participating dentists, benefit claims are reimbursed based on the lesser of the dentist's submitted fee for his or her service or the maximum allowable amount for participating dentists, as described below. Participating dentists accept the amount that Delta Dental determines to be the maximum allowable for participating dentists as payment in full.

If a Delta Dental PPO participating dentist provides treatment, the benefit claim will be reimbursed based on the dentist's submitted fee for his or her service or the maximum allowable amount for Delta Dental PPO participating dentists, whichever is less. You are responsible for paying the dentist for any non-covered charges, deductible and co-payment amounts, and any charges over your plan maximum.

If a Delta Dental Premier participating dentist provides treatment, the benefit claim will be reimbursed based on the dentist's submitted fee for his or her service or the maximum allowable amount for Delta Dental Premier participating dentists, whichever is less. You are responsible for paying the dentist for any non-covered charges, deductible and co-payment amounts, and any charges over your plan maximum.

For a list of Delta Dental Participating Dentists, you may contact DDPOK at 405-607-2100 or toll-free at 800-522-0188. You may also obtain a customized list of Participating Dentists within your geographic area or nationwide by searching the internet at www.DeltaDentalOK.org.

Nonparticipating Dentists, Out-of-Network Services

If you obtain treatment from a dentist who has not signed a participating agreement with Delta Dental, any benefit payment will be paid directly to you, unless otherwise required by law, and will be based on the lesser of the dentist's submitted fee or the prevailing fee. Prevailing fee is an amount established by the Delta Dental Plan in the state in which the dental services are rendered. You are responsible for paying the dentist and for filing your own claim.

Emergency Care and Claim Predetermination

If you require emergency care, there is no preauthorization requirement. If the cost of the dental care you need is less than $250, your participating dentist will probably proceed with treatment. If the cost estimate is more than $250 and the treatment is not emergency care, your dentist can determine the treatment needed and submit a treatment plan to DDPOK for predetermination of benefits. This procedure will enable you and the dentist to know in advance of treatment what services are covered, how much of the cost will be paid by your dental plan, and how much of the cost you will be responsible for paying.

This plan does not require any preauthorization for any dental services; however, said services are subject to the plan's specific limitations, non-covered charges, deductibles, and co-payment amounts, as well as any charges over your plan maximum.

Note: Please keep in mind, the Predetermination of Benefits is only an estimate and not a guarantee of payment. The patient must be eligible for Benefits at the time services are actually rendered, and the procedure must be a Covered Service on the date of service.

Claim Filing

You or someone in the dental office must complete the information portion of the claim form with the Subscriber's full name, Subscriber's social security number or, if applicable, unique identification number; the name and date of birth of the person receiving dental care; and the group name and number.

If you have any questions about the plan, please check with your employer's benefits office or contact Delta Dental Plan of Oklahoma, Customer Service Department, P.O. Box 54709, Oklahoma City, Oklahoma 73154-1709. You may also contact Delta Dental Plan of Oklahoma by email at CustomerService@DeltaDentalOK.org. *All correspondence with DDPOK should include the group name and group number; the Subscriber's social security number, or, if applicable, unique identification number, telephone number, and address; name of patient; and date of service.*

Once treatment is completed, the participating dentist will submit the claim form to Delta Dental Plan of Oklahoma for payment.

Subscribers, Dependents, and Beneficiaries can obtain, without charge, the necessary claim filing forms from DDPOK. The complete claim appeal procedure is furnished upon request by the Plan Administrator, without charge.

Claim Filing Deadline

The Plan is not obligated to pay any claim submitted later than 12 months following the date of service.

WARNING: *Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.*

Explanation of Benefits

Anytime a claim is filed, by you or a dentist, you will receive a form called an Explanation of Benefits (EOB) from Delta Dental Plan of Oklahoma within a reasonable time, but no later than 30 days after receipt of a claim. DDPOK may extend this time period one time up to 15 days, prior to the expiration of the 30-day period. If DDPOK requires additional information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will be given 45 days from receipt of the notice within which to provide the necessary information.

The EOB indicates what services were covered and what services, if any, were not. You are responsible to pay only the amount designated as "Patient Payment"; if you are billed for amounts over those identified, please contact DDPOK's customer service department. An explanation of how to appeal a claim is included on the EOB, as well as in this Certificate. ***PLEASE NOTE: If the "Patient Pays" amount on an EOB is $0.00, the EOB will not be mailed to you unless DDPOK is requesting additional information to finalize the claim. A copy of any of your applicable EOBs may be obtained from DDPOK's online system.***

Coordination of Benefits

The Coordination of Benefits provision is designed to provide maximum coverage if a patient is eligible for benefits under two or more dental plans and more than one of those plans provides coverage for a particular service. In no event will either plan pay a greater amount than it would have paid had dual coverage not existed, and the dental programs together will not pay more than 100% of covered expenses.

HOW TO APPEAL A CLAIM

Claim Benefits Determination

A copy of the Explanation of Benefits will be sent to the Subscriber by DDPOK, indicating if any services are denied, in whole or in part, and stating the reason or reasons for the benefits determination, according to the time frame described in the Explanation of Benefits section in this Summary Plan Description.

Appeal of Claim Benefits Determination

Within 180 days after receipt of a notice of benefits determination, a Subscriber or dentist may make a written request for review of such benefits determination by addressing the request to Delta Dental Plan of Oklahoma, P.O. Box 54709, Oklahoma City, Oklahoma 73154, or Appeals@DeltaDentalOK.org, stating the reason(s) re-evaluation of the benefits determination is being requested. The Subscriber or dentist may submit written comments, documents, records, and other information relating to the claim for benefits. As a Subscriber, you may request reasonable access to and, at no charge, copies of all documents, records, and other information relevant to your claim for benefits. All requests for review of benefits determinations shall be made taking into account all comments, documents, records, and other information submitted by the Subscriber relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Full and Fair Review of Request

DDPOK shall make a full and fair review of each request for re-evaluation and may require additional documents as it deems necessary or desirable in making such a review. The Subscriber shall receive a decision on his/her initial request for a review, in writing, within 30 days after DDPOK receives the request.

If the Subscriber wishes to have the initial review determination appealed further, the Subscriber must make a written request for a second review of the benefits determination by addressing the request to Oklahoma County Benefits and Retirement Department, 320 Robert S. Kerr, Room 220, Oklahoma City, Oklahoma, 73102, stating the reason(s) re-evaluation of the denial is being requested. The Subscriber shall receive a decision on his/her second request for a review, in writing, within 60 days after the Oklahoma County Budget Board receives the second request.

Any complaints other than those involving the denial of services should also be addressed, in writing, to the office identified above. Such complaints will be reviewed according to the same procedure. The complete claim appeal procedure is furnished upon request, without charge, as a separate document.

GENERAL INFORMATION

Assignment

Services to eligible persons are for the personal benefit of such persons and cannot be transferred or assigned. Any attempt to do so shall automatically terminate all rights of the eligible person, except in those states where assignment is required by law.

Obtaining and Releasing Information

To determine how the terms of this Certificate shall be applied and implemented, DDPOK may, without the consent of or notice to any eligible person, release to or obtain from any insurance company, group hospitalization plan, or dental care plan any information with respect to payments or benefits which it deems to be necessary for such purposes.
Any eligible person claiming benefits under this plan shall furnish DDPOK such information as may be necessary to implement this provision.

Doctor-Patient Relationship

The eligible person has freedom of choice of any properly licensed dentist. Each dentist rendering service under this Certificate is an independent contractor and shall maintain the doctor-patient relationship with his/her patient hereunder and shall be solely responsible to the patient for dental advice and treatment or any liability resulting there from.

E-Mail Communications

Delta Dental of Oklahoma and its authorized service providers may, from time to time, send you unencrypted email messages containing notifications, reminders, tips, and links to surveys and information related to your dental plan for treatment, payment, and healthcare operations purposes. Although minimal, some Protected Health Information (PHI) may be included in these email messages, e.g., identifying that you are enrolled in a dental plan for which Delta Dental serves as Claims Administrator and recently visited a dentist. Since the messages are unencrypted, there is some risk the messages could be read by someone other than you. Because a risk exists, privacy laws and regulations require your consent for the unencrypted transmission of PHI. If you choose to receive these email communications, please indicate your consent by accessing Delta Dental of Oklahoma's member website at https://Spotlight.DeltaDentalOK.org.

You are not required to provide this consent for unencrypted email messages, and once given, you may rescind the consent in the future. Your employer and Delta Dental of Oklahoma will not condition your eligibility for benefits, treatment, enrollment, or payment of claims on whether you provide this consent.

THIS CERTIFICATE IS ONLY A SUMMARY OF THE DENTAL PLAN, NOT A CONTRACT. ALL BENEFITS ARE GOVERNED BY, AND SUBJECT TO, THE PROVISIONS OF THE PLAN AGREEMENT BETWEEN YOUR EMPLOYER OR REPRESENTATIVE OF YOUR GROUP AND DELTA DENTAL PLAN OF OKLAHOMA.

SUMMARY OF DENTAL PLAN BENEFITS

SUPPLEMENTAL PLAN DESCRIPTION

NAME OF PLAN	Oklahoma County Group Dental Plan Group No. 2975
PLAN SPONSOR/ EMPLOYER/ PLAN ADMINISTRATOR	Oklahoma County 320 Robert S. Kerr Oklahoma City, Oklahoma 73102
EMPLOYER ID NO.	73-6006400
AGENT FOR LEGAL SERVICE	Oklahoma County 320 Robert S. Kerr Oklahoma City, Oklahoma 73102
TYPE OF PLAN	Employee Welfare Benefit Plan
PLAN COSTS	The cost of the Plan is funded by contributions by the Employer and the Employee
PLAN BENEFIT YEAR	January 1 – December 31
CLAIMS ADMINISTRATOR	Delta Dental Plan of Oklahoma P.O. Box 54709 Oklahoma City, Oklahoma 73154 (405) 607-2100 or (800) 522-0188
	Claims Filing Address: Delta Dental of Oklahoma P.O. Box 548809 Oklahoma City, Oklahoma 73154-8809

SELECTED BENEFITS

The dental services included in the Plan Sponsor's group dental plan are listed in this Summary, under "Description of Covered Services", and described by classes of service. The percentage next to each class of service represents that portion of the dentist's charge or the maximum allowable amount, whichever is less, the Plan will pay after you satisfy any applicable deductible. ***Note: Some benefits are subject to limitations, e.g. age of patient, frequency of procedure, etc., or excluded in some instances. Please review "LIMITATIONS" and "EXCLUSIONS" in this Summary.***

If your employer provides the opportunity, you may be eligible for additional preventive dental with the Health though Oral Wellness® (HOW®) program.

To participate in the HOW® program, you must receive a qualifying clinical risk assessment from your dentist. Based on your risk scores, and subject to the provisions of your dental Benefits plan, you may be eligible for additional diagnostic and preventive Benefits.

MAXIMUM CONTRACT BENEFIT

The maximum benefit payable for combined Class I, Class II, and Class III covered dental services rendered to an eligible person during the benefit year shall be $3,000. The maximum benefit payable for covered Class IV covered services rendered to an eligible dependent child during the benefit year shall be $1,200.

Note: Benefits payable by the Plan for covered oral evaluations (examinations) and routine prophylaxis (cleaning) will not reduce the maximum benefit per person during the benefit year for combined Class I, Class II, and Class III covered dental services.

DEDUCTIBLE

A $25 deductible applies to Class II and Class III covered services, per person per benefit year. The deductible may be met in Class II services or Class III services, or in any combination of Class II and Class III services. The maximum family deductible is $125 per benefit year. *Note: The Deductible is not applicable to Class I or Class IV services.*

DESCRIPTION OF COVERED SERVICES

CLASS I SERVICES – 100%

Diagnostic Services: Procedures performed by properly licensed dentists in evaluating existing conditions to determine the required dental treatment. By way of description, such covered services include: Oral evaluations, palliative treatment of dental pain, and radiographic images (x-rays).

Preventive Services: Procedures performed by properly licensed dentists to prevent the occurrence of disease. By way of description, such covered services include: Routine prophylaxis (cleaning) and scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation; and topical application of fluoride, limited sealants, and space maintainers for eligible dependent children.

CLASS II SERVICES – 80%

Basic Restorative Services: Procedures performed by properly licensed dentists in the treatment of carious lesions (decay/cavity). By way of description, such covered services include: Amalgam and composite restorations (fillings); and stainless steel restorations (crowns) for eligible dependent children.

Oral Surgery Services: Procedures performed by properly licensed dentists for extractions and other oral surgical procedures.

Endodontic Services: Procedures performed by properly licensed dentists for the treatment of non-vital teeth. By way of description, such covered services include: Pulpal therapy and root canal treatment.

Periodontic Services: Procedures performed by properly licensed dentists for the treatment of diseases of the gums and supporting structures of the teeth, including, but not limited to, periodontal maintenance procedures following active therapy. *Note: Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation is payable as a Class I service.*

Prosthodontic Services: Re-cementing fixed partial dentures (bridges) and adjustment or repair to dentures.

CLASS III SERVICES – 70%

Major Restorative Services: Provides porcelain or cast restorations (other than stainless steel) for the treatment of carious lesions (decay/cavity) when teeth cannot be restored with another filling material. ***Note: A crown or cast restoration is optional treatment unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or resin restoration.***

Prosthodontic Services: Procedures for construction of fixed partial dentures (bridges), removable partial dentures, and complete dentures.

Implant Services: Procedures for implant placement, implant-supported prosthetics, and maintenance and repair of implants and implant-supported prosthetics.

CLASS IV SERVICES – 80% (Available only to eligible Dependent Children)

Orthodontic Services: The necessary treatment and procedures required for the correction of malposed teeth.

LIMITATIONS

The benefits to be provided to Subscribers and eligible Dependents under this Plan shall be limited as follows:

- To be eligible for coverage, a service must be required for the prevention, diagnosis, or treatment of a dental disease, injury, or condition. Services not dentally necessary are not covered benefits. Your dental plan is designed to assist you in maintaining dental health. The fact that a procedure is prescribed or rendered by your dentist does not make it dentally necessary or eligible under this plan.
- For purposes of this Plan, any procedure frequency limitation is measured in a period of continuous calendar-year months (a consecutive-month period), which begins on the date of service for which the procedure was last paid.
- Prophylaxis is a benefit twice in a 12 consecutive month period. ***Note 1****: Cleanings/prophylaxis of any type, including periodontal maintenance and scaling in presence of generalized moderate or severe gingival inflammation, are limited to any combination of two in a 12 consecutive month period.* ***Note 2****: If a participant in the HOW® program, the patient may be eligible for additional prophylaxis, periodontal maintenance, or scaling in presence of generalized moderate or severe gingival inflammation.*
- Oral evaluation is a benefit twice a 12 consecutive month period.
- Limited (emergency) oral evaluation is a benefit twice in a 12 consecutive month period. ***Note****: Benefits for limited (emergency) oral evaluation may not be billable to the patient if other services are provided on the same day.*
- Consultation (D9310) is a benefit once in a 12 consecutive month period.
- Bitewing radiographic images are a benefit once in a 12 consecutive month period. ***Note****: Benefits may be limited if multiple same-day x-rays are provided on the same day by the same dentist/dental office.*
- Full-mouth radiographic images, a panoramic radiographic image, multiple same-day radiographic images, or vertical bitewings-7 to 8 films are a benefit once in a 60 consecutive month period unless necessary for the diagnosis and treatment of a specific disease or injury.
- Topical application of fluoride solutions is a benefit for patients through age 18, and once in a 12 consecutive month period. ***Note****: If a participant in the HOW® program, the patient may be eligible for additional topical application of fluoride.*
- A space maintainer is a benefit for missing primary posterior teeth for persons through age 15, and not for orthodontic purposes.
- Sealants are a benefit for persons through age 15, limited to permanent first and second molar teeth free of caries and restorations on the occlusal surfaces. Sealants are a benefit once per tooth in a 60 consecutive month period. ***Note****: If a participant in the HOW® program, the patient may be eligible for additional sealants.*
- Stainless steel crowns are a benefit only for persons through age 11, and once per tooth in an 84 consecutive month period.
- General anesthesia/IV sedation is a benefit only when administered by a properly licensed dentist in a dental office in conjunction with oral surgical procedures when covered, or when necessary due to concurrent medical conditions. Otherwise, the fee for general anesthesia/IV sedation is denied. The fee for general anesthesia/IV sedation is denied when billed by anyone other than a licensed dentist.
- Payment is made for a single tooth surface repair once in a 24 consecutive month period, regardless of the number of combinations of restorations placed therein.
- Root canal therapy is a benefit once per tooth in a 36 consecutive month period.
- Prosthodontics: (1) An upper or lower denture is a payable benefit once per arch in a 60 consecutive month period; (2) a removable partial denture or fixed partial denture (bridge) may not be provided more often than once per arch in any 60 consecutive month period, except where the loss of additional teeth requires the construction of a new appliance; (3) reline and rebase is a benefit once in any 36 consecutive month period for any one appliance; and (4) fixed partial dentures (bridges) and removable partial dentures are benefits for persons age 16 and over.
- Single crowns/onlays/veneers on the same tooth are a benefit for persons age 12 and over, and once in an 84 consecutive month period.
- Implant Benefits: The implant and the associated crown over the implant are a benefit for persons 16 years of age and over, limited to once in an eighty-four (84) consecutive month period. Some implant procedures or procedures associated with implants are not covered services under the plan and no benefits will accrue or be payable for those excluded procedures.
- Comprehensive Orthodontic Benefits: (1) Benefits are available only to eligible dependent children under age 26; (2) treatment must begin on or after the eligible person's effective date of orthodontic coverage under this Plan, or be active and ongoing on such person's effective date of orthodontic coverage under this Plan; (3) treatment must be provided by a licensed dentist, or overseen by a dental professional when using at-home method; (4) benefits are limited to traditional methods; If non-traditional methods are utilized, the patient is responsible for the difference between the non-traditional method charge and the approved amount for the traditional method; (5) benefits are limited to periodic payments over the term of the comprehensive treatment plan; and (6) benefits cease the last day of the month in which: (a) such person

receiving comprehensive orthodontic treatment becomes ineligible for coverage under this Plan, (b) orthodontic treatment is terminated for any reason before completion of the treatment plan, (c) orthodontic treatment is completed, (d) the maximum orthodontic benefit has been paid, or (e) orthodontic benefits are discontinued under the plan by the Plan Administrator, whichever occurs first.

- Limited Orthodontic Benefits: (1) Benefits are available only to eligible dependent children under the age of 26; (2) treatment must begin on or after the eligible person's effective date of orthodontic coverage under this Plan; (3) treatment must be provided by a licensed dentist, or overseen by a dental professional when using at-home method; (4) benefits are limited to traditional methods; If non-traditional methods are utilized, the patient is responsible for the difference between the non-traditional method charge and the approved amount for the traditional method; (5) benefits are limited to lump-sum payment each benefit year, as opposed to periodic payments; and (6) benefits cease the last day of the month in which: (a) such person receiving limited orthodontic treatment becomes ineligible for coverage under this Plan, (b) the maximum orthodontic benefit has been paid, or (c) orthodontic benefits are discontinued under the plan by the Plan Administrator, whichever occurs first.
- Alternate Benefits/Optional Treatment: The Plan may consider alternate dental services that are suitable for care of a specific condition if those alternate services will produce a professionally acceptable result, as determined by DDPOK. If patient and dentist elect other treatment, patient will be responsible for any charges in excess of the Plan's payment.
- The Plan's obligation to provide benefits for covered dental services terminates on the last day of the month in which the patient becomes ineligible for benefits under this Plan.
- Care terminated due to death will be paid in full, to the limit of the Plan's liability, for services completed or in progress.
- When services in progress are interrupted and completed later by another dentist, DDPOK will review the claim to determine the payment to each dentist.
- Processing policies, if applied, may limit benefits and can be found on each Explanation of Benefits.
- Charges for any covered dental service or supplies which are included as covered medical expenses under the plan of Major Medical or Comprehensive Medical Expense Benefits Plan must first be submitted for payment to the medical carrier. The Plan may benefit as the secondary carrier.
- Nutritional counseling, tobacco counseling, and oral hygiene instruction may be a Benefit if the patient is a participant in the HOW® program.

EXCLUSIONS

The following shall be excluded from the benefits to be provided to Subscribers and eligible Dependents.

- Benefits or services for injuries or conditions compensable under Workers' Compensation or Employers' Liability laws.
- Benefits or services available from any federal or state government agency, or from any municipality, county, or other political subdivision or community agency, or from any foundation or similar entity.
- Charges for services or supplies for which no charge is made that the patient is legally obligated to pay or for which no charge would be made in the absence of dental coverage.
- Benefits for services or appliances started prior to the date the patient became eligible under this Plan may be excluded.
- Benefits for services when a claim is received for payment more than 12 months after services are rendered.
- Charges for any professional services performed by a relative of the patient.
- Charges for treatment by other than a properly licensed dentist (unless allowed by state law), except radiographic images (x-rays) ordered by a dentist, cleaning and scaling of teeth, and topical application of fluoride may be performed by a properly licensed hygienist if treatment is rendered under the supervision and guidance of the dentist, in accordance with generally accepted dental standards.
- Charges for completion of forms or submission of documentation required by DDPOK for a benefit determination. Such charges are not billable to the patient when services are provided by a Delta Dental Participating Dentist, and the patient cannot be charged by the participating dentist. Such charges are denied if submitted by a nonparticipating dentist.
- Charges for house calls, hospital calls, or office visits.
- Charges for missed or cancelled appointments, hospitalization or additional fees charged for hospital treatment.
- Charges for bleaching of teeth.
- Prescription drugs and pre-medications.
- Experimental procedures.
- Charges for occlusal guards.
- Charges for orthodontic treatment, except as specifically provided under the plan.
- Charges for replacement of lost or missing crowns or appliances, for replacement of stolen appliances, or for repair of an orthodontic appliance.

- Benefits or services to correct congenital or developmental malformations.
- Services for the purpose of improving appearance when form and function are satisfactory and there is insufficient pathological condition evident to warrant the treatment (cosmetic dentistry).
- Restorations for altering occlusion (bite), involving vertical dimensions, replacing tooth structure lost by attrition (grinding of teeth), erosion, abrasion (wear), or for periodontal, orthodontic, or other splinting.
- Services with respect to diagnosis and treatment of disturbances of the temporomandibular joint (TMJ).
- All other benefits and services not specified in the Plan Agreement, including but not limited to the following excluded services. ***Note: Some excluded procedure codes listed below are preceded by one or more asterisks. Following is a brief explanation of what the asterisk(s) preceding an excluded code means:***

*	***Indicates an orthodontic procedure. Orthodontic services will be allowed if the plan stipulates orthodontic coverage.***
**	***Indicates the fee for the procedure or service is not billable to the patient, which means it is not benefited by the plan, nor is the charge collectable from the patient if the service is provided by a Delta Dental Participating Dentist.***
***	***Indicates the procedure is not billable to the patient when submitted by a Delta Dental Participating Dentist for periodontal probing and/or laser disinfection (laser charges) in conjunction with other services. The procedure may be denied when submitted for other miscellaneous periodontal procedures or as a stand-alone procedure.***
****	***Indicates the procedure may be covered if the patient meets the necessary criteria to qualify for additional diagnostic and preventive benefits based on the HOW® program.***

Excluded Procedure Code	Description of Excluded Procedures
D0171	Re-evaluation-post operative office visit
D0190/D0191	Screening of a patient/Assessment of a patient
D0250/D0251	Extra-oral radiographic images
D0310	Sialography
D0320-D0322	TMJ radiographic images and tomographic survey
*D0340/D0350	Cephalometric radiographic image/2D oral-facial photographic images
D0364-D0368	Cone beam CT - image capture and interpretation
D0369	Maxillofacial MRI capture and interpretation
D0370	Maxillofacial ultrasound capture and interpretation
D0371	Sialoendoscopy capture and interpretation
D0372-D0374	Intraoral tomosynthesis radiographic images
D0380-D0384	Cone beam CT
D0385	Maxillofacial MRI image capture
D0386	Maxillofacial ultrasound image capture
**D0387	Intraoral tomosynthesis – comprehensive series of radiographic images – capture only
**D0388	Intraoral tomosynthesis – bitewing radiographic image – capture only
**D0389	Intraoral tomosynthesis – periapical radiographic image – capture only
D0391	Interpretation of diagnostic image by practitioner not associated with capture of the image, including report
D0393-D0395	Post processing of image or image sets
D0396	3D printing of a 3D dental surface scan
D0411	HbA1c In-office point of service testing
D0412	Blood glucose level test – in office using a glucose meter
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report
D0415/D0416	Bacteriologic studies/Viral culture
D0417/D0418	Collection and preparation of saliva sample for laboratory diagnostic testing/Analysis of saliva sample
D0422	Collection and preparation of genetic sample material for laboratory analysis and report
D0423	Genetic test for susceptibility to diseases–specimen analysis
****D0425	Caries susceptibility test
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities

Excluded Procedure Code	Description of Excluded Procedures
*D0470	Diagnostic cast
**D0472-D0474	Accession of tissue
**D0475-D0479	Oral pathology tests and examinations
**D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report
**D0481-D0483	Oral pathology laboratory procedures
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source
**D0486	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report
D0502	Oral pathology procedures
**D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum
D0604-D0606	Testing for a public health related pathogen, including coronavirus
**D0701	Panoramic radiographic image – image capture only
**D0702/D0703	2-D cephalometric radiographic image – image capture only/2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only
**D0705-D0709	Radiographic images – image capture only
D0801/D0802	3D dental surface scan – direct/3D dental surface scan – indirect
D0803/D0804	3D facial surface scan – direct/3D facial surface scan - indirect
D0999	Unspecified diagnostic procedure
D1301	Immunization counseling
****D1310	Nutritional counseling
****D1320	Tobacco counseling regarding oral disease
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use
****D1330	Oral hygiene instructions
D1355	Caries preventive medicament application – per tooth
D1701-D1714	COVID 19 vaccine administration
D1781-D1783	Vaccine administration – human papillomavirus
D1999	Unspecified preventive procedure, by report
D2410-D2430	Gold foil restorations
**D2949	Restorative foundation for an indirect restoration
**D2953	Each additional cast post-same tooth
**D2957	Each additional prefab post-same tooth
D2975	Coping
D2981	Inlay repair, necessitated by restorative material failure
**D2989	Excavation of a tooth resulting in the determination of non-restorability
D2990	Resin infiltration of incipient smooth surface lesions
D2991	Application of hydroxyapatite regeneration medicament – per tooth
D2999	Unspecified restorative procedure
**D3110-D3120	Pulp caps
**D3331	Treatment of root canal obstruction
D3333	Internal root repair of perforation defects
D3355-D3357	Pulpal regeneration; does not include final restoration
D3428-D3429	Bone graft in conjunction with periradicular surgery
D3460	Endodontic endosseous implant
D3470	Intentional reimplantation
**D3910	Isolation of tooth with rubber dam
**D3911	Intraorifice barrier
D3921	Decoronation or submergence of an erupted tooth
**D3950	Canal preparation and fitting of post
D3999	Unspecified endodontic procedure
D4230-D4231	Anatomical crown exposure
**D4286	Removal of non-resorbable barrier

Excluded Procedure Code	Description of Excluded Procedures
D4322/D4323	Splint – intra-coronal; natural teeth or prosthetic crowns/Splint – extra-coronal; natural teeth or prosthetic crowns
D4381	Localized delivery of antimicrobial agents via release vehicle into diseased crevicular tissue, per tooth
**D4920	Unscheduled dressing change
D4921	Gingival irrigation with medicinal agent – per quadrant
***D4999	Unspecified periodontal procedure
D5810-D5811	Interim complete dentures
D5862	Precision attachment, by report
D5867	Replacement of replaceable part of semi- precision or precision attachment, per attachment
D5876	Add metal substructure to acrylic full denture, per arch
D5899	Unspecified removable prosthodontic procedure, by report
D5911-D5999	Maxillofacial prosthetics
**D6011	Surgical access to an implant body (second stage implant surgery)
D6040-D6050	Implant services
D6051	Interim implant abutment placement
D6089	Accessing and retorquing loose implant screw – per screw
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment
D6103	Bone graft for repair of periimplant defect
D6104	Bone graft at time of implant placement
D6118-D6119	Implant/abutment supported interim fixed denture for edentulous arch
D6190	Radiographic/surgical implant index, by report
**D6198	Remove interim implant component
D6199	Unspecified implant services
**D6253	Interim pontic – further treatment or completion of diagnosis necessary prior to final impression
D6548	Retainer-porcelain/ceramic
D6600-D6607	Inlays
D6624	Inlay-titanium
**D6793	Interim retainer crown – further treatment or completion of diagnosis necessary prior to final impression
D6920/D6940	Connector bar/Stress breaker
D6950	Precision attachment
D6985	Pediatric partial denture, fixed
D6999	Unspecified fixed prosthodontic procedure
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth re-implantation and/or stabilization
D7272	Tooth transplantation
*D7280	Surgical exposure of unerupted tooth
D7282	Mobilization of erupted or malpositioned tooth to aid eruption
*D7283	Placement of device to facilitate eruption of impacted tooth
D7285-D7286	Incisional biopsy of oral tissue
D7287	Cytology sample collection
*D7290	Surgical repositioning of teeth
*D7291	Transseptal fiberotomy, by report
D7292-D7294	Placement of temporary anchorage device
D7295	Harvest of bone for use in autogenous grafting procedure
D7296-D7297	Corticotomy
D7298-D7300	Removal of temporary anchorage device
**D7310/D7311	Alveoloplasty in conjunction with extractions
D7320-D7321	Alveoloplasty not in conjunction with extractions
D7340-D7350	Vestibuloplasty
D7410-D7465	Surgical excision of soft tissue/intra-osseous lesions

Excluded Procedure Code	Description of Excluded Procedures
D7471-D7490	Excision of bone tissue
D7509	Marsupialization of odontogenic cyst
**D7511	Incision and drainage of abscess-intraoral soft tissue-complicated
D7520-D7560	Surgical incision
D7610-D7780	Treatment of fractures
D7810-D7899	Reduction of dislocation & mgmt. of TMJ
**D7910	Suture of recent small wounds up to 5 cm
D7911-D7912	Complicated suturing
D7920-D7921	Other repair procedures
**D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation
D7940-D7955	Other repair procedures
D7961-D7962	Other repair procedures
**D7963	Frenuloplasty
**D7970-D7971	Other repair procedures
D7972-D7999	Other repair procedures
*D8000-D8670	Orthodontic services
**D8680-D8681	Other orthodontic services
D8695	Removal of fixed orthodontic appliance(s) – other than at the conclusion of treatment
D8696-D8697	Other orthodontic services
**D8698-D8702	Other orthodontic services
*D8703-D8704	Other orthodontic services
D8999	Unspecified orthodontic service
D9130	Temporomandibular joint dysfunction, non-invasive physical therapies
**D9210-D9215	Anesthesia
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia
D9248	Non-intravenous moderate (conscious) sedation
**D9311	Consultation with a medical health care professional
D9410-D9450	Professional visits
D9610-D9630	Drugs
D9910-D9911	Miscellaneous services
**D9912	Pre-visit patient screening
D9920-D9930	Miscellaneous services
D9932-D9935	Cleaning and inspection of dentures/partials
D9938/D9939	Fabrication of a custom removable clear plastic temporary aesthetic appliance/Placement of a custom removable clear plastic temporary aesthetic appliance
D9941-D9987	Miscellaneous services
**D9990	Certified translation or sign language services, per visit
**D9991-D9992	Dental case management – addressing appointment compliance barriers/Dental case management – care coordination
D9993-D9994	Dental case management – motivational interviewing/patient education to improve oral health literacy
**D9997	Dental case management – patients with special health care needs
D9999	Miscellaneous services