

Delta Dental PPOSM

EXHIBIT B

Our national
PPO plus Premier
program



Welcome!

Your dental program is administered by Delta Dental of North Carolina, a North Carolina nonprofit health service plan corporation. Delta Dental of North Carolina is the state's dental benefits specialist. Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Certificate, along with your Summary of Dental Plan Benefits, describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call our Customer Service department at (800) 662-8856 or access our website at www.deltadentalnc.com.

You can easily verify your own benefit, claims and eligibility information online 24 hours a day, seven days a week by visiting www.deltadentalnc.com and selecting the link for our Consumer Toolkit. The Consumer Toolkit will also allow you to print claim forms and ID cards, select paperless explanation of benefits (EOBs), search our dentist directories, and read oral health tips. We look forward to serving you!

THIS IS A LEGAL CONTRACT. Please read it carefully.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENTAL CERTIFICATE.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company. Title II NCAC 12.0943 and Section 17.E.

Important Cancellation Information

Please read the provision entitled "Termination of Coverage" found on page 15.

TABLE OF CONTENTS

I.	Certificate.....	2
II.	Definitions.....	2
III.	Selecting a Dentist	5
IV.	Accessing Your Benefits	5
V.	How Payment is Made	7
VI.	Benefit Categories.....	7
VII.	Exclusions and Limitations.....	8
VIII.	Coordination of Benefits.....	12
IX.	Disputed Claims Procedure.....	14
X.	Termination of Coverage	15
XI.	Continuation of Coverage.....	16
XII.	General Conditions	16

THIS IS A LEGAL CONTRACT. Please read it carefully.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENTAL CERTIFICATE.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company. Title II NCAC 12.0943 and Section 17.E.

Important Cancellation Information

Please read the provision entitled “Termination of Coverage” found on page 15.

Note: This Certificate should be read in conjunction with the Summary of Dental Plan Benefits that is provided with the Certificate. The Summary of Dental Plan Benefits lists the specific provisions of your group dental Plan and supersedes any contrary provision of this Certificate.

I. Delta Dental PPO Certificate

Delta Dental of North Carolina, referred to herein as Delta Dental, issues this Certificate to you, the Subscriber. The Certificate is an easy-to-read summary of your dental benefits Plan. It reflects and is subject to the agreement between Delta Dental and your employer or organization.

The benefits provided under the Plan may change if any state or federal laws change.

Delta Dental agrees to provide dental benefits as described in this Certificate.

All the provisions in the following pages form a part of this document as fully as if they were stated over the signature below.

IN WITNESS WHEREOF, this Certificate is executed at Delta Dental's home office by an authorized officer.



Curtis R. Ladig, CPA
President and CEO
Delta Dental of North Carolina

II. Definitions

Benefit Year

Normally, the calendar year, unless your employer or organization elects a different period to serve as the Benefit Year. (See the Summary of Dental Plan Benefits for your Benefit Year.)

Certificate

This document. Delta Dental will provide dental benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the Plan.

Children or Child

Your natural children, stepchildren, foster children, adopted children, children by virtue of legal guardianship, or children who are residing with you

during the waiting period for adoption or legal guardianship.

Completion Dates

Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- ◆ For dentures and partial dentures, on the delivery dates;
- ◆ For crowns and bridgework, on the cementation dates;
- ◆ For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Concurrent Care Claims

Claims for benefits where an ongoing course of treatment has been agreed to by Delta Dental and/or the administrator of your Plan and the coverage for that treatment is reduced or terminated before the treatment has been completed. A Concurrent Care Claim may also arise if you ask the Plan to extend coverage beyond the time period or number of treatments previously agreed to.

Control Plan (Delta Dental)

Delta Dental acts as the Control Plan for your contract. The Control Plan will provide all claims processing, service, and administration for your group. The Control Plan will be referred to as Delta Dental in this document.

Copayment

As provided by your Plan, the percentage of the charge, if any, that you will have to pay for Covered Services.

Covered Services

The unique benefits selected in your Plan. The Summary of Dental Plan Benefits provided with this Certificate lists the Covered Services provided by your Plan.

Deductible

The amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for services. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

Delta Dental

Means Delta Dental of North Carolina, a North Carolina nonprofit health service plan corporation providing dental benefits. Delta Dental is not a commercial insurance company.

Delta Dental Plan

An individual dental benefit plan that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

Delta Dental PPO plus Premier

Delta Dental's national preferred provider organization program that can reduce your out-of-pocket expenses if you receive care from one of Delta Dental's PPO Dentists. This program has back-up coverage through the Delta Dental Premier network when treatment is received from a Non-PPO Dentist.

Delta Dental Premier

Delta Dental's national fee-for-service dental benefits program that covers you when you go to a Non-PPO Dentist.



Dentist

A person licensed to practice dentistry in the state or jurisdiction in which dental services are rendered.

- ◆ **Delta Dental PPO Dentist (PPO Dentist)** – a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental PPO. PPO Dentists agree to accept Delta Dental's payment and the Eligible Person's Copayment, if any, as payment in full for Covered Services.

- ◆ **Delta Dental Premier Dentist (Premier Dentist)** – a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental Premier. Premier Dentists agree to accept the Maximum Approved Fee as payment in full for Covered Services.
- ◆ **Nonparticipating Dentist** – a Dentist who has not signed an agreement with any Delta Dental Plan to participate in Delta Dental PPO or Delta Dental Premier.
- ◆ **Out-of-Country Dentist** – a Dentist whose office is located outside of the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental, but may participate in the Passport Dental program.

PPO Dentists and Premier Dentists are sometimes collectively referred to herein as "**Participating Dentists**". Wherever a definition or provision of this Contract differs from another state's Delta Dental Plan and its agreement with a Participating Dentist, the agreement in that state with that Dentist shall be controlling.

Premier Dentists, Nonparticipating Dentists, and Out-of-Country Dentists are sometimes collectively referred to herein as "**Non-PPO Dentists**".

Eligible Dependent

The Summary of Dental Plan Benefits will have specific information about your Plan's rules for dependent eligibility but, generally, your Eligible Dependents are:

- ◆ Your legal spouse;
- ◆ Your unmarried Children who have not yet reached the end of the calendar year of their 19th birthday;
- ◆ Your unmarried Children who have reached the end of the calendar year of their 19th birthday and who are chiefly dependent on you for support and maintenance;
- ◆ Any unmarried Children for whom you or your legal spouse are financially responsible for medical, health, or dental care under the terms of a court decree or who have been named as alternate recipients under a qualified medical child support order; and
- ◆ Your Children who have reached the end of the calendar year of their 19th birthday, but who were

at that time (and continue to be), totally and permanently disabled by a physical or mental condition and who are chiefly dependent upon you for support and maintenance. If Delta Dental asks you to do so, you must submit medical reports confirming your Child's initial disability within 31 days of the end of the calendar year of that Child's 19th birthday. Thereafter, Delta Dental may request proof of your Child's continuing disability, but no more frequently than annually.

Eligible Person

Any Subscriber or Eligible Dependent with coverage under the Plan.

Maximum Approved Fee

A system used by Delta Dental to determine the approved fee for a given procedure for a given Participating Dentist. A fee meets Maximum Approved Fee requirements if it is the lowest of:

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

Delta Dental may also approve a fee under unusual circumstances.

Participating Dentists are not allowed to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Payment

The maximum dollar amount Delta Dental will pay in any benefit year or lifetime for covered dental services. (See the Summary of Dental Plan Benefits.)

Nonparticipating Dentist Fee

The maximum fee that Delta Dental will pay per procedure for services rendered by a Nonparticipating Dentist.

Out-of-Country Dentist Fee

The maximum fee that Delta Dental will pay per procedure for services rendered by an Out-of-Country Dentist.

Plan

The arrangement for the provision of dental benefits to Eligible Persons established by the contract between Delta Dental and your employer or organization.

Post-Service Claims

Claims for benefits that are not conditioned on your seeking advance approval, certification, or authorization to receive the full amount of any covered benefit. In other words, Post-Service Claims arise when you receive the dental service or treatment before you file a claim for the benefit payment.

PPO Dentist Schedule

The maximum fee allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Plan.

Premier Dentist Schedule

The maximum fee allowed per procedure for services rendered by a Premier Dentist as determined by that Dentist's local Delta Dental Plan.

Predetermination

Predetermination is a voluntary, optional procedure where Delta Dental issues a written estimate of Benefits which may be available under your Plan for your proposed dental treatment. Your Dentist submits the proposed dental treatment to Delta Dental in advance of providing the treatment.

Predetermination is provided for informational purposes only and is not required before you receive any dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same Benefits under your Plan whether or not a Predetermination is requested. The Benefits estimate provided on a Predetermination notice is based on Benefits available on the date the notice is issued. It is not a guarantee of future Benefits or payment.

Availability of Benefits at the time your treatment is completed depends on several factors such as, but not limited to, your continued eligibility for Benefits, your

available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Plan and your Dentist, your Plan's limitations and any other Plan provisions. A request for a Predetermination is not a claim for Benefits or a preauthorization, precertification or other reservation of future Benefits.

Processing Policies

Delta Dental's policies and guidelines used for Predetermination and payment of claims. The Processing Policies may be amended from time to time.

Submitted Amount

The amount a Dentist bills to Delta Dental for a specific treatment or service.

Subscriber

You, when your employer or organization notifies Delta Dental that you are eligible to receive dental benefits under your employer's or organization's Plan.

Summary of Dental Plan Benefits

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

III. Selecting a Dentist

You may choose any Dentist. Your out-of-pocket costs are likely to be less if you go to a Delta Dental PPO Dentist. PPO Dentists agree to accept payment according to the PPO Dentist Schedule, and, in most cases, this results in a reduction of their fees. Delta Dental may also pay a higher percentage for Covered Services if you go to a PPO Dentist. If the Dentist you select is not a PPO Dentist, you will still be covered. Your coverage levels may be slightly lower, but you can still save money. In this case, there are two options:

- ◆ If you go to a Non-PPO Dentist who participates in Delta Dental Premier, the fee reduction is not the same as with the PPO Dentists. However, Premier Dentists agree to accept Delta Dental's Maximum Approved Fee as payment in full for Covered Services.
- ◆ If you choose a Dentist who does not participate in either program, you will be responsible for any difference between Delta Dental's allowed fee

and the Dentist's Submitted Amount, in addition to any Copayments and/or Deductibles.



To verify that a Dentist is a Participating Dentist, you can use Delta Dental's online Dentist Directory at www.deltadentalnc.com or call (800) 662-8856.

IV. Accessing Your Benefits

To use your Plan, follow these steps:

1. Please read this Certificate and the Summary of Dental Plan Benefits carefully so you are familiar with the benefits, payment mechanisms, and provisions of your Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits coverage with Delta Dental. If your Dentist is not familiar with your Plan or has questions about the Plan, have him or her contact Delta Dental by (a) writing Delta Dental, Attention: Customer Service, P.O. Box 9089, Farmington Hills, Michigan, 48333-9089, or (b) calling the toll-free number, (800) 662-8856.
3. After you receive your dental treatment, you or the dental office staff will file a claim form, completing the information portion with:
 - a. The Subscriber's full name and address;
 - b. The Subscriber's Member ID number;
 - c. The name and date of birth of the person receiving dental care;
 - d. The group's name and number.

Notice of Claim Forms

Delta Dental does not require special claim forms. However, most dental offices have claim forms available. Participating Dentists will fill out and submit your claims paperwork for you.

Claims and completed information requests should be mailed to:

Delta Dental
P.O. Box 9085
Farmington Hills, Michigan 48333-9085

Written Notice of Claim/Time of Payment

Because the amount of your benefits is not conditioned on a Predetermination decision by Delta Dental, all claims under this Plan are Post-Service Claims. Once a claim is filed, Delta Dental will decide it within 30 days of receiving the proof of loss. If there is not enough information to decide your claim, Delta Dental will notify you or your Dentist within 30 days. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the claim, and (d) inform you or your Dentist that the information must be received within 90 days or your claim will be denied. You will receive a copy of any notice that is sent to your Dentist. Once Delta Dental receives the requested information, it will have 30 days to decide your claim. If you or your Dentist fails to supply the requested information, Delta Dental will have no choice but to deny your claim. Once Delta Dental decides your claim, it will notify you within five days.

Proof of Loss

Written proof of loss must be given within one year after such loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time unless the claimant was legally incapacitated.

Concurrent Care Claims

If you have been approved for a course of treatment and that course of treatment is reduced or terminated before it has been completed, or if you wish to extend the course of treatment beyond what was agreed upon,

you may file a Concurrent Care Claim seeking to restore the remainder of the treatment regimen or extend the course of treatment. All Concurrent Care Claims will be decided in sufficient time so that, if your claim is denied (in whole or in part), you can seek a review of that decision before the course of treatment is scheduled to terminate.

Authorized Representative

You may also appoint an authorized representative to deal with the Plan on your behalf with respect to any benefit claim you file or any review of a denied claim you wish to pursue (see the Disputed Claims Procedure section). You should contact your Human Resources department, call Delta Dental's Customer Service department, toll-free, at (800) 662-8856, or write them at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089, to request a form to fill out designating the person you wish to appoint as your representative. While in some circumstances your Dentist may be treated as your authorized representative, generally only the person you have authorized on the last dated form filed with Delta Dental will be recognized. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not inform you of the status of your claim. You will have to get that information from your representative. If you have not designated a representative, Delta Dental will communicate with you directly.

Predetermination Estimate

Delta Dental recommends Predetermination before your Dentist provides any services where the total charges will exceed \$200. Predetermination is not a prerequisite to payment, but it allows claims to be processed more efficiently and allows you to know what services may be covered before your Dentist provides them. You and your Dentist should review your Predetermination Notice before treatment. Once treatment is complete, the dental office will enter the dates of service on the Predetermination Notice and submit it to Delta Dental for payment.

Questions?

Questions regarding your Plan or coverage should be directed to your Human Resources department or call Delta Dental's Customer Service department, toll-free, at (800) 662-8856. You may also write to Delta Dental's Customer Service department, P.O. Box 9089, Farmington Hills, Michigan, 48333-9089. When

writing to Delta Dental, please include your name, the group's name and number, the Subscriber's Member ID number, and your daytime telephone number.

V. How Payment is Made

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

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

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

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

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

VI. Benefit Categories

Important

Eligible people are entitled to ONLY those benefits listed in the Summary of Dental Plan Benefits. The following is a description of various dental benefits that can be selected for a dental program. Please be certain to review the Exclusions and Limitations section regarding the benefit information listed below.

Diagnostic and Preventive Services

Diagnostic and Preventive Services

Services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease. These services include examinations/evaluations, prophylaxes (cleanings), space maintainers, and fluoride treatments.

Brush Biopsy

Oral brush biopsy procedure and laboratory analysis to detect oral cancer. Using this diagnostic procedure, dentists can identify and treat abnormal cells that could become cancerous, or they can detect the disease in its earliest and most treatable stage. The test is quick, accurate, and involves little or no patient discomfort.

Emergency Palliative Treatment

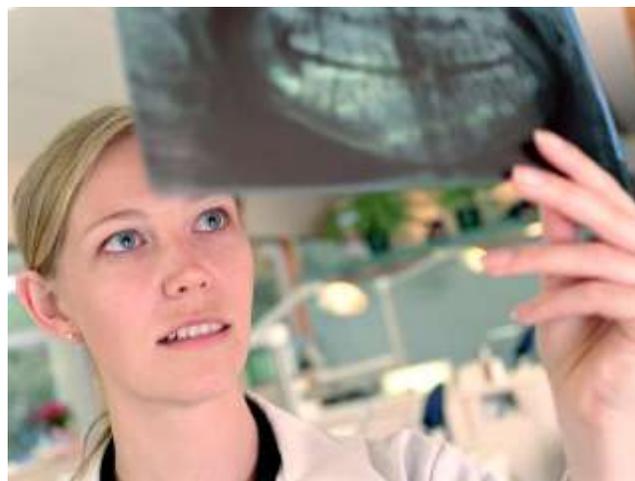
Emergency treatment to temporarily relieve pain.

Sealants

A resinous material applied to the occlusal surface of posterior teeth to prevent decay.

Radiographs

X-rays as required for routine care or as necessary for the diagnosis of a specific condition.



Basic Services

Oral Surgery Services

Extractions and dental surgery, including pre-operative and post-operative care.

Endodontic Services

The treatment of teeth with diseased or damaged nerves (for example, root canals).

Periodontic Services

The treatment of diseases of the gums and supporting structures of the teeth. This includes periodontal maintenance following active therapy (teeth cleaning by a specialist).

Restorative Services

Services to rebuild and repair natural tooth structure damaged by disease or injury. Restorative services include:

- ◆ Minor restorative services, such as amalgam (silver) fillings and composite resin (white) fillings.
- ◆ Major restorative services, such as crowns, used when teeth cannot be restored with another filling material.

Major Services

Relines and Repairs

Relines and repairs to partial and complete dentures, and repairs to bridges.

Prosthodontic Services

Services and appliances that replace missing natural teeth (such as bridges, endosteal implants, partial dentures, and complete dentures).

Orthodontic Services

Services, treatment, and procedures to correct malposed teeth (such as braces).

Other Benefits

The Summary of Dental Plan Benefits lists any other benefits that may have been selected.

VII. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the following services or supplies will be the responsibility of the Eligible Person (though the Eligible Person's payment obligation may be satisfied by insurance or some other arrangement for which he or she is eligible):

1. Services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina Worker's Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
2. Benefits or services received from any government agency, political subdivision, community agency, foundation, or similar entity.

NOTE: This provision does not apply to any programs provided under Title XIX Social Security Act; that is, Medicaid.

3. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations, except that when a child covered from the moment of birth or placement in the adoptive home requires dental care associated with congenital defects and anomalies, congenital defects will be covered to the same extent an otherwise Covered Service is provided by the Plan.
4. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental, except that when a Child covered from the moment of birth or placement in the adoptive home requires dental care associated with congenital defects and anomalies, congenital defects will be covered to the same extent an otherwise Covered Service is provided by the Plan
5. Services or appliances started before a person became eligible under this Plan. This exclusion

- does not apply to orthodontic treatment in progress (if a Covered Service).
6. Prescription drugs (except intramuscular injectable antibiotics), premedications, medicaments/solutions, and relative analgesia.
 7. General anesthesia and/or intravenous sedation for surgical procedures, unless medically necessary, or for restorative dentistry.
 8. Charges for hospitalization, laboratory tests, and histopathological examinations.
 9. Charges for failure to keep a scheduled visit with the Dentist.
 10. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
 11. Services or supplies, as determined by Delta Dental, that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
 12. Specialized techniques, as determined by Delta Dental.
 13. Services or supplies, as determined by Delta Dental, which are not rendered in accordance with generally accepted standards of dental practice.
 14. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist or other dental professional as determined by Delta Dental under the scope of his or her license as permitted by applicable state law.
 15. Services or supplies excluded by the policies and procedures of Delta Dental, including the Processing Policies.
 16. Services or supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
 17. Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
 18. Services or supplies that are covered under a hospital, surgical/medical, or prescription drug program.
 19. Services or supplies that are not within the categories of benefits that have been selected and that are not covered in the Plan.
 20. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
 21. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
 22. Space maintainers for maintaining space due to premature loss of anterior primary teeth.
 23. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
 24. Cosmetic dentistry, as determined by Delta Dental, except that when a Child covered from the moment of birth or placement in the adoptive home requires dental care associated with congenital defects and anomalies, congenital defects will be covered to the same extent an otherwise Covered Service is provided by the Plan.
 25. Veneers.
 26. Prefabricated crowns used as final restorations on permanent teeth.
 27. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If orthodontic services are Covered Services, this exclusion will not apply to orthodontic services as limited by the terms and conditions of the Plan.
 28. Paste-type root canal fillings on permanent teeth.
 29. Replacement, repair, relines, or adjustments of occlusal guards.
 30. Chemical curettage.
 31. Services associated with overdentures.
 32. Metal bases on removable prostheses.
 33. The replacement of teeth beyond the normal complement of teeth.
 34. Personalization/characterization of any service or appliance.
 35. Temporary crowns used for temporization during crown or bridge fabrication.
 36. Posterior bridges in conjunction with partial dentures in the same arch.

37. Precision attachments and stress breakers.
38. Specialized implant surgical techniques, including a radiographic/surgical implant index.
39. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
40. Diagnostic photographs, diagnostic casts (study models), and cephalometric films, unless done for orthodontics.
41. Myofunctional therapy.
42. Mounted case analyses.

Delta Dental will make no payment for the following services or supplies. Participating Dentists may not charge Eligible Persons for these services or supplies. All charges from Nonparticipating Dentists for the following services or supplies will be the responsibility of the Eligible Person:

1. The completion of forms or submission of claims.
2. Consultations, when performed in conjunction with examinations/evaluations.
3. Local anesthesia.
4. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
5. Infection control.
6. Temporary crowns.
7. Gingivectomy as an aid to the placement of a restoration.
8. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
9. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
10. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
11. Post-operative X-rays, when done following any completed service or procedure.
12. Periodontal charting.
13. Pins and/or preformed posts, when done with core buildups for crowns, onlays, or inlays.
14. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary

filling, when done with pulpal debridement for the relief of acute pain before conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.

15. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
16. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
17. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
18. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling and root planing.
19. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
20. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
21. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be the responsibility of the Eligible Person. All time limitations are measured from the last date of service in any Delta Dental Plan record or, at the request of your group, any dental plan record:

1. Bitewing X-rays are payable once per calendar year. Full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period. A panoramic X-ray (including bitewings) is considered a full mouth X-ray.
2. Any combination of prophylaxes (teeth cleanings) and periodontal maintenance procedures are payable twice per calendar year.
3. Oral examinations/evaluations are only payable twice per calendar year, regardless of the Dentist's specialty.
4. Preventive fluoride treatments are payable twice per calendar year for people under age 19.

5. Space maintainers are payable for people under age 14.
6. Sealants are payable once per tooth per lifetime for the occlusal surface of first and second permanent molars for people under age 16. The surface must be free from decay and restorations.
7. Cast restorations (including jackets, crowns, and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth.
8. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) and/or fracture.
9. Individual crowns over implants are payable at the prosthodontic benefit level.
10. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people under age 12.
11. An occlusal guard is payable once in a lifetime.
12. An interim partial denture is payable only for the replacement of permanent anterior teeth for people under age 17 or during the healing period for people age 17 and over.
13. Prosthodontic Services limitations:
 - a. One complete upper and one complete lower denture are payable once in any five-year period.
 - b. A removable partial denture, implant, or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
 - c. Fixed bridges and removable cast partial dentures are not payable for people under age 16.
 - d. A reline or the complete replacement of denture base material is payable once in any two-year period per appliance.
 - e. Implant removal is payable once per lifetime per tooth or area.
 - f. Implant maintenance is payable once per calendar year.
14. Orthodontic Services limitations:
 - a. Orthodontic benefits are payable for people under age 19.
- b. If the treatment plan is terminated before completion of the case for any reason, Delta Dental's obligation for payment of benefits ends on the last day of the month in which the patient was last treated.
- c. The Dentist may terminate treatment, with written notification to Delta Dental and to the patient, for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment of benefits ends on the last day of the month in which the patient was last treated.
- d. An observation and adjustment is a benefit twice in a 12-month period.
15. Delta Dental's obligation for payment of benefits ends on the last day of coverage. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as it receives a claim for those services within one year of the date of service. Failure to submit a claim within the time required does not invalidate or reduce any claim however, if it was not reasonably possible for the claimant to file the claim within that time, provided that the claim is submitted as soon as possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time submittal of the claim is otherwise required.
16. When services in progress are interrupted and completed later by another Dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each Dentist.
17. Care terminated due to the death of an Eligible Person will be paid to the limit of Delta Dental's liability for the services completed or in progress.
18. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental will make an allowance based on the fee for the customarily provided service. You are responsible for the difference in cost.

Listed below are some examples of optional services. Remember, you are responsible for the difference in cost for any optional treatment.

 - a. Overdentures – the Plan will pay only the applicable amount that it would pay for a conventional denture.
 - b. Inlays, regardless of the material used – the Plan will pay only the applicable amount that

it would pay for an amalgam or composite resin restoration.

- c. All-porcelain/ceramic bridges – the Plan will pay only the applicable amount that it would pay for a conventional fixed bridge.
- d. Implant/abutment supported complete or partial dentures – the Plan will pay only the applicable amount that it would pay for a conventional denture.

19. Maximum Payment:

- a. The maximum benefit payable in any one benefit year will be limited to the Maximum Payment specified in the Summary of Dental Plan Benefits.
- b. Delta Dental’s payment for Orthodontic Services will be limited to the annual or lifetime Maximum Payment specified in the Summary of Dental Plan Benefits.

20. If a Plan Deductible amount is specified in the Summary of Dental Plan Benefits, Delta Dental will not be obligated to pay for any services or supplies, in whole or in part, to which the Deductible applies until the Plan Deductible amount is met.

21. Processing Policies may limit Delta Dental’s payment for dental services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. Participating Dentists may not charge Eligible Persons for these services or supplies. All charges from Nonparticipating Dentists that exceed these limitations will be the responsibility of the Eligible Person:

1. Amalgam and composite resin restorations by the same Dentist or dental office are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
3. Recementation of a crown, onlay, inlay, space maintainer, or bridge by the same Dentist or dental office within six months of the seating date.
4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.

5. Root planing by the same Dentist or dental office is payable once in any two-year period.
6. Periodontal surgery by the same Dentist or dental office is payable once in any three-year period.
7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
8. Tissue conditioning is not payable more than twice per arch in any three-year period.
9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
10. Services or supplies, as determined by Delta Dental, which are not rendered in accordance with generally accepted standards of dental practice.
11. Processing Policies may limit Delta Dental’s payment for dental services or supplies.

VIII. Coordination of Benefits

Coordination of Benefits (COB) applies to this Plan when you or your Eligible Dependents are covered under more than one Plan.

In that case, North Carolina COB rules determine whether this Plan’s benefits are determined before or after another plan’s benefits. When this Plan is a Primary Plan, its benefits are determined before the other plan’s benefits and without considering those benefits. When this Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of those benefits.

When you are covered by more than two plans, this Plan may be a Primary Plan as to one or more of those plans and may be a Secondary Plan as to the other plans.

Which Plan is Primary?

In general, this Plan is a Secondary Plan. Its benefits are determined after the other plan’s benefits, unless:

1. The other plan has rules coordinating its benefits with this Plan’s benefits; and

2. Those rules and this Plan's rules require that this Plan's benefits be determined first.

Delta Dental determines which plan is the Primary Plan by using the first of the following rules that applies:

1. The benefits of the plan that covers you as an employee or a Subscriber (that is, as other than a dependent) are determined before those of the plan that covers you as a dependent. This rule does not apply if you are also a Medicare beneficiary and, as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - a. Secondary to the plan covering you as a dependent; and
 - b. Primary to the plan covering you as other than a dependent (for example, as a retired employee).
2. Delta Dental uses the birthday rule when more than one plan covers a dependent child of parents who are not divorced or separated. Under this rule:
 - a. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before the benefits of the plan of the parent whose birthday falls later in that year, but
 - b. If both parents have the same birthday, the benefits of the plan that covered the parents longer are determined before the benefits of the plan that covered them for a shorter period of time.

If the other plan does not use the birthday rule, but instead uses a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the other plan's rule determines the order of benefits.

3. When more than one plan covers a dependent child of divorced or separated parents, the child's benefits are determined in this order:
 - a. First, the plan of the parent with custody of the Child;
 - b. Then, the plan of the spouse of the parent with custody of the Child;
 - c. Then, the plan of the parent without custody of the Child; and
 - d. Then, the plan of the spouse of the parent without custody of the Child.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the entity obligated to pay or provide the benefits of that parent's plan has actual knowledge of those terms, that plan's benefits are determined first. The other parent's plan is the Secondary Plan. This paragraph does not apply with respect to any benefit year during which any benefits are actually paid or provided before the entity has that actual knowledge. If the specific terms of the court decree state that the parents will share custody without stating that one of the parents is responsible for the child's health care expenses, the plans covering the Child are subject to the birthday rule.

4. The benefits of a plan that covers you as an employee who is neither laid off nor retired (or as your dependent) are determined before those of a plan that covers you as a laid-off or retired employee (or as your dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
5. If your coverage is provided under a right of continuation pursuant to federal law (COBRA) or state law and you are also covered under another plan, the benefits of the plan covering you as an employee or a Subscriber (or as your dependent) will be determined before the benefits under the continuation coverage. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
6. If none of the above rules determines the order of benefits, the benefits of the plan that covered you longer are determined before those of the Plan that covered you for the shorter term.

How Delta Dental Pays as Primary Plan

When Delta Dental is the Primary Plan, it will pay for Covered Services as if you had no other coverage.



How Delta Dental Pays as Secondary Plan

When Delta Dental is the Secondary Plan, it will pay for Covered Services based on the amount left after the Primary Plan has paid. It will not pay more than that amount, and it will not pay more than it would have paid as the Primary Plan. Delta Dental may, however, pay less than it would have paid as the Primary Plan.

When Delta Dental's payments are reduced as described above, each payment is reduced in proportion. The payments are then charged against any applicable benefit limit.

Right to Receive and Release Needed Information

Delta Dental needs certain facts to apply these COB rules, and it has the right to decide which facts it needs. It may get needed facts from, or give them to, any other organization or person. Delta Dental need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Delta Dental any facts it needs to pay the claim.

Facility of Payment

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

That amount will then be treated as though it were a benefit paid under this Plan, and Delta Dental will not have to pay that amount again. The term "payment

made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If Delta Dental pays more than it should have paid under this COB provision, it may recover the excess from the people it has paid or for whom it has paid.

Payment includes the reasonable cash value of any benefits provided in the form of services. This right of recovery is limited to two years after the date of the original claim payment, unless Delta Dental has reasonable belief that fraud or intentional misconduct occurred.

IX. Disputed Claims Procedure

Delta Dental will notify you or your authorized representative if you receive an adverse benefit determination after your claim is filed. An adverse benefit determination is any denial, reduction, or termination of the benefit for which you filed a claim, or a failure to provide or to make payment (in whole or in part) of the benefit you sought. This includes any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational or was not medically necessary or appropriate. If Delta Dental informs you that the Plan will pay the benefit you sought but will not pay the total amount of medical expenses incurred, and you must make a Copayment to satisfy the balance, you may also treat that as an adverse benefit determination.

If you receive notice of an adverse benefit determination, and if you think that Delta Dental incorrectly denied all or part of your claim, you can take the following steps:

First, you or your Dentist should contact Delta Dental's Customer Service department at their toll-free number, (800) 662-8856, and ask them to check the claim to make sure it was processed correctly. You may also mail your inquiry to the Customer Service department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089. When writing, please enclose a copy of your Explanation of Benefits and describe the problem. Be sure to include your name, your telephone number, the date, and any information you

would like considered about your claim. This inquiry is not required, and it should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems and submit information that might indicate that your claim was improperly denied and allow Delta Dental to correct this error quickly.

Formal Disputed Claims Procedure

Whether or not you have asked Delta Dental informally, as described above, to recheck its initial determination, you can submit your claim to a formal review through the Disputed Claims Procedure described here. To request a formal dispute of your claim, you must send your request in writing to:

**Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916**

You must include your name and address, the Subscriber's Member ID number, the reason you believe your claim was wrongly denied, and any other information you believe supports your claim, and indicate in your letter that you are requesting a formal dispute of your claim. You also have the right to review the Plan and any documents related to it. If you would like a record of your request and proof that it was received by Delta Dental, you should mail it certified mail, return receipt requested.

You or your authorized representative should seek a review as soon as possible, but you must file your dispute within 180 days of the date on which you receive your notice of the adverse benefit determination. If you are disputing an adverse determination of a Concurrent Care Claim, you will have to do so as soon as possible so that you may receive a decision on review before the course of treatment you are seeking to extend terminates.

The Dental Director or any other person(s) reviewing your claim will not be the same as, nor will they be subordinate to, the person(s) who initially decided your claim. The Dental Director will grant no deference to the prior decision about your claim. Instead, he will assess the information, including any additional information that you have provided, as if he were deciding the claim for the first time.

The Dental Director will make his decision within 30 days of receiving your request for the review of Pre-Service Claims and within 60 days for Post-Service Claims. If your claim is denied on review (in whole or

in part), you will be notified in writing. The notice of any adverse determination by the Dental Director will (a) inform you of the specific reason(s) for the denial, (b) list the pertinent Plan provision(s) on which the denial is based, (c) contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed, (d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review and inform you that a copy can be obtained upon request at no charge, (e) contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the Dental Director's decision to deny your claim (in whole or in part), and (f) contain a statement that you may seek to have your claim paid by bringing a civil action in court if it is denied again on dispute.

If the Dental Director's adverse determination is based on an assessment of medical or dental judgment or necessity, the notice of his adverse determination will explain the scientific or clinical judgment on which the determination was based or include a statement that a copy of the basis for that judgment can be obtained upon request at no charge. If the Dental Director consulted medical or dental experts in the appropriate specialty, the notice will contain the name(s) of those expert(s).

If your claim is denied in whole or in part after you have completed this required Disputed Claims Procedure, or if Delta Dental fails to comply with any of the deadlines contained therein, you have the right to seek to have your claim paid by filing a civil action in court. However, you will not be able to do so unless you have completed the review described above. If you wish to file your claim in court, you must do so within one year of the date on which you receive notice of the final denial of your claim.

X. Termination of Coverage

Delta Dental must give your employer or organization at least 45 days advance notice of cancellation, expiration, non-renewal, or a change in rates. In the event Delta Dental chooses to terminate the Plan due to nonpayment of premium, Delta Dental will give your employer or organization notice of the termination within 45 days after the premium due date. The effective date of such termination shall be the first day of the period for which the premium is due and not paid.

Your Delta Dental coverage may automatically terminate:

- ◆ When your employer or organization advises Delta Dental to terminate your coverage.
- ◆ On the first day of the month for which your employer or organization has failed to pay Delta Dental.

Delta Dental will not continue eligibility for any person covered under this program beyond the eligibility termination date requested by your employer or organization. A person whose eligibility is terminated may not continue group coverage under this Contract, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or comparable, non-preempted state law.

XI. Continuation of Coverage

If your employer or organization is required to comply with provisions under COBRA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and your coverage would otherwise end, you and/or your covered Eligible Dependents have the right under certain circumstances to continue coverage in the medical and dental plans sponsored by your employer or organization, at your expense, beyond the time coverage would normally end.

When is Plan Continuation Coverage Available?

Continuation coverage is available if your coverage or a covered Eligible Dependent's coverage would otherwise end because:

1. Your employment ends for any reason other than your gross misconduct;
2. Your hours of work are reduced so that you are no longer a full-time employee;
3. You are divorced or legally separated;
4. You die;
5. Your Child is no longer eligible to be a covered Eligible Dependent (for example, because he or she turns 19);
6. You become enrolled in Medicare (if applicable); or

7. You are called to active duty in the armed forces of the United States.

If you believe you are entitled to continuation coverage, you should contact your employer or organization to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 (ERISA).

XII. General Conditions

Change of Status

You must notify Delta Dental, through your employer or organization, of any event that changes the status of an Eligible Dependent. Events that can affect the status of an Eligible Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

In no event will retroactive updates to eligibility be accepted for an effective date more than 90 days prior to receipt of the update by Delta Dental.

Notwithstanding the foregoing, when no additional premium is required, a newborn child will be covered from the moment of birth, and a foster child or adopted child will be covered from the date of placement in the home, without regard to the timeliness of the update to eligibility.

Assignment

Services and/or benefit payments to Eligible Persons are for the personal benefit of those people and cannot be transferred or assigned, other than to the extent necessary to allow direct payments to Participating Dentists.

Obtaining and Releasing Information

While you are covered by Delta Dental, you agree to provide Delta Dental with any information it needs to process your claims and administer your benefits. This includes allowing Delta Dental to have access to your dental records.

Late Claims Submission

Delta Dental will make no payment for services if a claim for those services has not been received by Delta Dental within one year following the date the services were completed. Failure to submit a claim within the time required does not invalidate or reduce any claim however, if it was not reasonably possible for the

claimant to file the claim within that time, provided that the claim is submitted as soon as possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time submittal of the claim is otherwise required.

Dentist-Patient Relationship

Eligible Persons are free to choose any Dentist. Each Dentist maintains the dentist-patient relationship with the patient and is solely responsible to the patient for dental advice and treatment and any resulting liability.



Loss of Eligibility During Treatment

If an Eligible Person loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under the Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within a 60-day period measured from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental.

Entire Contract/Changes

This Certificate, along with your Summary of Dental Plan Benefits, constitutes the entire contract of your Delta Dental program. No agent has the authority to change any provisions in this Certificate or the provisions of the contract on which it is based. No changes to this Certificate or the underlying contract are valid unless Delta Dental approves them in writing.

Note: This Certificate and your Plan are subject to change if, in the future, federal or state laws or regulations require Delta Dental or your employer or organization to comply with such laws or regulations.

Legal Actions

No action on a legal claim arising out of or related to this Certificate will be brought until 60 days after the time written proof of loss is required to be given. In

addition, no action can be brought more than three years after the legal claim first arose. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim.

Governing Law

The group contract and/or Certificate will be governed by and interpreted under the laws of the state of North Carolina.

Right of Recovery Due to Fraud

If Delta Dental pays for dental services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a claim that contains false or misrepresented information, or pays a claim that is determined to be fraudulent due to the acts of the Eligible Person, it may recover that payment from the Eligible Person. The Eligible Person authorizes Delta Dental to recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to the Eligible Person. Delta Dental will provide an explanation of the payment being recovered at the time the deduction is made.

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for the Subscriber or an Eligible Dependent than is provided by this Certificate, that law shall control over the language of this Certificate.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. Only anti-fraud calls can be accepted on this line.

ANTI-FRAUD TOLL-FREE HOTLINE:

(800) 524-0147



Claims, Predeterminations

P.O. Box 9085
Farmington Hills, MI 48333-9085

Inquiries, Review

P.O. Box 9089
Farmington Hills, MI 48333-9089