DENTAL BENEFIT

INTRODUCTION

This section describes the dental benefits available to you under the Allegiant Care Dental Plan. Please review this section carefully to understand your coverage and how to use your benefits.

Claims for benefits under this Plan are processed by Northeast Delta Dental (Delta) under an administrative services agreement with Allegiant Care. If you have questions about participating providers, claims, or benefits, you can:

- Call Delta at **800-832-5700** (Monday through Friday, 8:00 a.m. to 8:00 p.m. EST).
- Use the 24-hour automated inquiry system at 800-253-7852.
- Visit ***www.nedelta.com/patients.***

PARTICIPATING DENTISTS

You may visit any dentist; however, choosing a participating dentist from the Delta Dental PPO or Premier Networks can make the process easier and help you save money.

Participating dentists:

- Prepare and submit claims directly to Delta on your behalf.
- Accept Delta's allowed fees for services and cannot "balance bill" you if their usual fee is higher.

For covered services, you are responsible only for your share of the cost—such as the deductible or the portion not paid by the Plan. For example, if the Plan pays 80% for basic services, your share is 20% of the allowed amount. You will not be asked to pay at the time of treatment for covered services, although your dentist may request payment for the deductible or your share of the cost.

NON-PARTICIPATING DENTISTS OR OTHER DENTAL PROVIDERS

You will get the best value when you use an in-network provider, but you may also choose to receive care from a non-participating dentist or another licensed dental provider. When doing so:

- You may be asked to pay for all services at the time they are provided.
- You may need to submit your own claim form, available at ***www.nedelta.com.***
- Payment will be limited to Delta's allowance for non-participating providers in the area where services are performed.
- You are responsible for your share of the allowed amount (deductible and coinsurance) **plus** the difference between the provider's charge and Delta's allowed amount.

Payment will generally be made to you when you receive services from a non-participating provider. If you prefer that payment be made directly to your dentist, you may authorize this by completing the assignment section on the claim form. Payment may be made to the dentist if permitted under applicable state law.

SCHEDULE OF BENEFITS

This chart shows the level of coverage for services provided by dentists who participate in the **Delta Dental PPO** or **Delta Dental Premier** networks. For the most up-to-date list of participating dentists, visit ***www.nedelta.com.***

<table>
<tr><th>Diagnostic/Preventive
Coverage A</th><th>Basic Restorative
Coverage B</th><th>Major Restorative
Coverage C</th></tr>
<tr><td>Deductible: None</td><td colspan="2">Deductible: $25 Individual /$50 Family (Coverages B and C only)</td></tr>
<tr><td>Covered at 100%</td><td>Covered at 80%</td><td>Covered at 50%</td></tr>
<tr><td rowspan="2">Diagnostic:
• Evaluations (twice/12 mos)
• X-Rays - Comprehensive series or panoramic film (once/3 yrs)
• Bitewing X-rays (once/12 mos)
• X-rays of individual teeth as necessary
Preventive:
• Cleanings (twice/12 mos)
• Fluoride (twice/12 mos <age 19)
• Space Maintainers (<age 16)
• Sealant treatment and sealant repair (unrestored permanent molars or bicuspids twice/lifetime/tooth <age 19)
• Occlusal guards (once/5 yrs)
• Athletic mouthguards (once/5yrs)
Emergency Palliative Treatment</td><td rowspan="2">Basic Restorative:
• Amalgam (silver) or Resin (white) fillings (once/24 mos)
• Prefabricated stainless steel crowns
Oral Surgery:
• Surgical and routine extractions
Endodontics:
• Root canal therapy
Periodontics:
• Periodontal maintenance (cleaning)
Note: Cleanings are limited to two in a 12 month period; these may be routine (Coverage A) or Periodontal (Coverage B), or a combination of both.
• Treatment of gum disease
• Clinical crown lengthening (once/tooth/lifetime)
• Brush biopsy (once/12 mos)</td><td>Major Restorative:
• Prefabricated resin, porcelain or ceramic crowns
• Crowns
• Onlays
• Inlays
Prosthodontics:
• Removable and fixed partial dentures (bridge)
• Complete dentures
• Rebase and reline (dentures)
• Repair of a removable denture to its original condition</td></tr>
<tr><td>Orthodontics
Coverage D
Deductible: None
Covered at 75%
Orthodontics:
Correction of malposed (crooked) teeth for dependent children and adults
Orthodontic Lifetime Maximum:
$1,500 Per Person</td></tr>
<tr><td colspan="3">Calendar Year Maximum: $2,000 per person (Coverages A, B and C)</td></tr>
</table>

This schedule is intended as a summary; certain benefit limitations and exclusions may apply. If there is any difference between this chart and the detailed information that follows, the detailed information will govern.

DEDUCTIBLE

Before the plan pays benefits for most dental care, you must first meet the annual deductible. The deductible does not apply to preventive care.

Each calendar year, you pay the first $25 of covered expenses for yourself and each covered dependent. Once your family's combined covered expenses reach $50, the family deductible is met, and no additional deductible applies for the rest of the year.

CALENDAR YEAR MAXIMUM

The plan provides up to $2,000 in dental benefits each calendar year for you and each of your covered family members. This annual maximum applies to all covered Diagnostic & Preventive, Basic Restorative and Major Restorative dental services (see Coverages A, B and C on the Benefit Schedule).

Annual Maximum Carryover

Through Delta's Double-Up Max℠ program, a portion of your unused annual maximum can carry over to future years when certain conditions are met.

- To qualify, you must have at least one paid claim during the year for an oral exam or cleaning, and your total paid claims for that year must not exceed $500.
- The carryover amount builds by $250 for each year you qualify, up to a total of $4,000 — double the plan's standard annual maximum of $2,000.

FREQUENCY AND AGE LIMITATIONS

The following limitations apply to your Dental Plan:

1. Periodic oral exams are covered twice in any 12-month period.
2. Routine or periodontal cleanings (prophylaxis) are covered twice in any 12-month period.
3. Topical fluoride application is covered twice in any 12-month period for dependents up to age 19.
4. Bitewing X-rays are covered once in any 12-month period.
5. Full mouth or panoramic X-rays are covered once in any 36-month period (combined).
6. Space maintainers are covered for dependents up to age 16.
7. Sealant treatment and sealant repair are covered a combined total of two times per unrestored permanent molar or bicuspid per lifetime for children up to age 19.
8. Replacement of an existing partial or full denture, or fixed bridgework, is covered once every 5 years, unless one of the following applies:
    a) Additional tooth loss makes a new appliance necessary.
    b) A tooth is extracted and must be added to an existing fixed partial denture.
    c) The existing appliance cannot be made serviceable.
9. Multiple restorations (fillings) on one surface of a tooth are considered a single procedure. Fillings are covered once per 24 months, per surface per tooth.

10. The minimum age for custom crowns, onlays, and inlays is 12.
11. The minimum age for dentures and implants is 16.
12. Crowns are covered once every five (5) years and only if the tooth cannot be adequately restored with a filling material such as amalgam.
13. A full denture is covered in the same arch once every five (5) years.
14. Denture relinings are covered twice every twelve (12) months; denture rebasings are covered once every five (5) years.
15. Orthodontic appliances are covered up to the lifetime maximum shown in your Schedule of Benefits.
16. Scaling and root planing performed on a "per quadrant" basis are covered once in any 24-month period.
17. Root canal therapy and root canal retreatment are covered once per tooth in any 36-month period. A retreatment counts as the same service for frequency purposes.
18. Mouth guards, night guards, occlusal guards, and athletic guards are covered once in any five-year period.

OTHER LIMITATIONS

If you choose a more expensive treatment than the standard procedure used to restore a tooth to normal function, the Plan will pay only the amount it would have paid for the standard procedure. You are responsible for the difference.

Diagnostic casts (study models) and photographs are included in the total orthodontic case fee and are not separately covered.

Benefits are paid for amalgam (silver) or resin (white) fillings when treating tooth decay. If you choose a more costly option—such as gold, an onlay, or a crown—you are responsible for the difference in cost.

PREDETERMINATION OF BENEFITS

Predetermination of benefits is recommended for costly or extensive treatment plans. While not required, it helps you and your dentist understand how much the plan is expected to pay and what portion you may be responsible for.

Please note that a predetermination is an estimate, not a guarantee of payment. The estimate is based on your current eligibility and benefits at the time the predetermination is issued. The final payment amount may differ if your coverage changes, if additional benefits are paid before the service is provided, or if the dentist's fee schedule or participating status changes.

The predetermination notice shows your estimated benefits based on the procedures and costs submitted by your dental office.

CLAIMS PROCESSING

Filings Claims

Claims must be submitted within two years from the date of service. No benefits will be paid for claims received after that time.

Completed claim forms and supporting documentation (such as x-rays for major services) should be submitted directly to:

Northeast Delta Dental
One Delta Drive, P.O. Box 2002
Concord, NH 03302-2002

Payment will be based on the plan's covered benefits, Delta's allowed amounts, and applicable limitations or exclusions. You and your dentist will receive an Explanation of Benefits showing the amount paid or the reason for any denial.

When a Service is Considered Incurred

The date of incurred liability is the date a covered service becomes subject to the deductible, coinsurance, and any applicable maximums or limitations. The total cost of a service is applied to the coverage period in which the service is completed, even if it began in a prior period.

For services completed over multiple visits, the incurred date is as follows:

- Crowns and Onlays: The cost is incurred on the date that the crown or onlay is cemented.
- Fixed Partial Dentures (bridges): The cost is incurred on the date the appliance is cemented.
- Removable Complete and Partial Dentures: The cost is incurred on the date the denture is delivered.
- Endodontic Treatment (root canals): The cost is incurred when the canal is filled to completion.
- Orthodontics - The initial charge is incurred when the first bands or appliance (or a portion thereof) is placed in the mouth. Ongoing charges are incurred with each monthly payment, for up to 24 months, as long as eligibility is maintained during the payment period.

COORDINATION OF BENEFITS

When You Are Covered Under More Than One Dental Plan

If you or your dependents are covered under more than one dental plan, benefits will be coordinated so that total payments do not exceed 100% of the allowable expense, in accordance with the Plan's general Coordination of Benefits provisions described in the Administrative Policies and Procedures section.

Frequency and time limitations apply even when benefits are coordinated under multiple plans (for example, two cleanings every twelve months).

Medical Coordination for Certain Dental Procedures

Some dental services may also be covered under your medical plan. In these cases, your medical coverage pays first, and additional coverage will be considered under your dental plan only after your medical plan has processed the claim.

If oral surgery or dental treatment is required because of an accident or injury, or for procedures such as the removal of impacted wisdom teeth, you or your provider should first submit the claim to your medical carrier. Once the medical plan has made payment (or issued a denial), submit the dental claim and a copy of the medical carrier's Explanation of Benefits to Delta for review and payment of any remaining eligible dental expenses.

DENTAL BENEFITS AFTER COVERAGE ENDS

Your dental coverage ends when your eligibility for benefits under the Plan terminates. The Plan does not pay for services or supplies provided after your coverage has ended, even if a pretreatment estimate or predetermination of benefits was previously issued.

DENTAL BENEFIT EXCLUSIONS

Your Dental Plan does not cover the following services. *Some of the services listed below may be covered under your medical, pharmacy, or other benefit plan, depending on your coverage.*

1. **Eligibility, Coverage Status, and Billing**

a) Services or supplies not listed as covered in the Schedule of Dental Benefits.

b) Charges incurred before your effective date, after your coverage ends, or after you have reached the Plan's annual or lifetime maximum.

c) Services for individuals who are not eligible dependents under this Plan.

d) Charges that exceed reasonable and customary levels.

e) Services for which no charge would have been made without dental benefits.

f) Charges for missed appointments ("no-show" fees) or for completion of forms.

g) Fees for transmitting data via teledentistry, which are considered part of the overall procedure.

2**. Non-Dental, Medical, or Non-Covered Provider Services**

a) Oral surgery or other procedures covered under your medical plan (for example, removal of a tumor).

b) Hospitalization or facility charges.

c) General anesthesia or IV sedation when used solely for restorative dentistry.

d) Prescription drugs, premedication, and related analgesia.

e) Services not performed by a dentist or dental hygienist under appropriate supervision, or outside the provider's scope of licensure.

f) Services provided by a U.S. government, state, or local facility, unless for emergency treatment and you are required to pay; or services payable under a national government plan.

3. **Services Not Considered Dentally Necessary**

a) Services that are not necessary and customary or do not meet accepted dental standards, including experimental or investigational procedures.

b) Temporary services or incomplete treatment.

c) Emergency exam charges when performed on the same visit as another procedure (except X-rays).

d) Duplicate dental services or appliances, including replacement of lost, missing, or stolen devices.

e) Fluoride rinses or any over-the-counter drug that can be purchased without a prescription.

f) Personalization or characterization of teeth or dentures, including precision attachments and overdentures.

g) A crown that is not required to restore a tooth.

4. **Cosmetic, Bite, Jaw Function, and Related Procedures**

a) Cosmetic services such as whitening, bleaching, veneers, or other aesthetic procedures. (Services for congenital defects or developmental malformations are not excluded.)

b) Appliances, procedures, or restorations intended for:

i. Increasing vertical dimension (changing the height of your bite)

ii. Analyzing, altering, restoring, or maintaining the bite (occlusion)

iii. Replacing tooth structure lost from wear (attrition) or abrasion

iv. Home sleep apnea testing or sleep-related appliances

v. Treatment of temporomandibular joint (TMJ) dysfunction and related diagnostics

vi. Splinting teeth together (extracoronal or intracoronal splinting)

i. Myofunctional therapy (muscle training exercises).

c) Equilibration (reshaping teeth to adjust the bite).

d) Gnathological reporting (specialized bite analysis).

5. **Implants and Other Non-Covered Procedures**

a) Implants (surgical placement of the root device).

b) Implant abutments (the connector placed on top of the implant).

c) Denture relining within six (6) months of initial placement.

d) Metal substructure for dentures.

e) Pulpal regeneration procedures.

6**. Exclusions Related to Injury, Employment, or Legal Responsibility**

a) Illness or injury resulting from an act of war (declared or undeclared) or occurring in connection with military service.

b) Illness or injury resulting from participation in an assault or felony.

c) Illness covered under Workers' Compensation, occupational disease law, or similar laws.

d) Injury or illness arising from employment for pay, profit, or gain.

e) Illness or injury caused by another person where recovery is available from that party or their insurer.

DISPUTED CLAIMS PROCEDURE

Level 1 - Delta Administrative Review

You must submit a written request for review within 180 days of the date on Delta's Explanation of Benefits (EOB). Your request should explain why you believe the decision was incorrect and include any supporting information. Delta will review your appeal and send you a written response, generally within 30 days of receiving your request. Level 1 Appeals should be sent to:

Vice President, Professional Relations
Northeast Delta Dental
One Delta Drive, P.O. Box 2002
Concord, NH 03302-2002

Level 2 - Delta Committee Review

If you disagree with the Level 1 decision, you may request a second-level review by Delta's Disputed Claims Review Committee. Your written request must be submitted within 180 days of the Level 1 decision. Delta will issue a written determination, generally within 30 days after receiving your request.

Level 3 - Final Appeal to Allegiant Care (Level 3)

If you disagree with the decision issued by Delta's Disputed Claims Review Committee, you may request a final review by Allegiant Care's Board of Trustees, which has the ultimate discretionary authority to interpret the Plan and determine eligibility for benefits. This request must be submitted in writing within 180 days of receiving Delta's final decision. Refer to the Administrative Policies and Procedures section for filing instructions.