State of Michigan

State Preventive Dental Plan

Delta Dental PPO™ Our national PPO program

utilizing our Delta Dental PPO™ and Delta Dental Premier® networks

WELCOME!

Delta Dental Plan of Michigan, Inc. is a nonprofit dental care corporation, doing business as Delta Dental of Michigan. Delta Dental of Michigan is the state's dental benefits specialist. Good oral health is a vital part of good general health, and your State Preventive Dental Plan is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

The benefits described in this booklet are provided under the self-funded State Preventive Dental Plan administered by Delta Dental Plan of Michigan, Inc. (Delta Dental) under the direction of the Michigan Civil Service Commission, Employee Benefits Division (MCSC, EBD). These benefits are not insured with Delta Dental, but will be payable from funds administered by MCSC, EBD.

MCSC, EBD is responsible for implementing State Preventive Dental Plan benefits and future changes in benefits. Delta Dental will provide certain services on behalf of MCSC, EBD through an administrative services only contract. Information concerning people enrolled under the State Preventive Dental Plan may be reviewed by Delta Dental of Michigan.

This document is not a contract. Rather, it is intended to be a summary description of benefits. Every effort has been made to ensure the accuracy of this benefit booklet. However, if statements in this booklet differ from applicable Delta Dental coverage documents, then the terms and conditions of those coverage documents will prevail.

The State Preventive Dental Plan is designed to encourage preventive dental care and assist you with the financial burden of dental bills. Please keep in mind that this Plan is not intended to cover the cost of all services. You should continue to discuss your dentist's charges with the dentist in advance of any treatment to determine your share of the cost.

Effective 1/1/2026

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State of Michigan Summary of Benefits **State Preventive Dental Plan**

Group No. 8700 (Active) and 8800 (COBRA)

Covered Services:	Delta Dental PPO Dentist		Delta Dental Premier Dentist		Nonparticipating Dentist*	
	Plan Pays	You Pay	Plan Pays	You Pay	Plan Pays	You Pay
Diagnostic & Preventive Services						
Diagnostic Services – Includes routine and emergency oral exams. Oral exams are limited to two times per Plan year.	100%	0%	100%	0%	100%	0%*
Preventive Services – Includes prophylaxes, space maintainers, and fluoride treatments. Prophylaxes (teeth cleanings) are limited to three times in a Plan year. Fluoride treatments for enrolled dependents up to age 19; and space maintainers for enrolled dependents to age 14.	100%	0%	100%	0%	100%	0%*
Radiographs – X-rays as required for routine care or as necessary for the diagnosis of a specific condition. Covered services include full mouth X-rays once in every five years and bitewing X-rays once in a Plan year unless special need is shown.	100%	0%	100%	0%	100%	0%*

*****In the event that you seek treatment from a nonparticipating dentist, you may be responsible for more than the percentage indicated above. Please see the "How Payment is Made" section of this certificate for additional details.

I. Eligibility Guidelines

Employees

You are eligible to enroll in the State Preventive Dental Plan on the first day of the biweekly payroll period following your enrollment, if you are:

- a Full-Time (FT) employee;
- a Part-Time (PT) or Job Sharing (JS) employee working 32 hours or more every biweekly pay period; or
- a Permanent Intermittent (PI) employee expected to work every biweekly pay period and at least 40 percent of full-time annually (a minimum of 832 hours).

A seasonal employee must have an appointment that lasts eight months or more a year.

Certain unclassified State employees are also eligible to enroll.

Your coverage is effective on the first day of the first pay period after you enroll.

An eligible employee who is not enrolled, but is covered by the enrollment of a spouse or parent, may enroll before or within 31 days after termination of the spouse's or parent's coverage. The effective date of coverage is the pay period begin date in which the coverage is lost.

Dependents

You may cover your legal spouse and eligible dependents in accordance with State of Michigan Dependent Eligibility Guidelines; visit mi.gov/docs4ebd for specific criteria. These dependents can include:

- children by birth, legal adoption, or stepchildren are eligible through the last day of the month in which they turn age 26.
- children the employee has legal guardianship of or foster care (placed in your home by a state agency or court) are eligible through the day before their 18th birthday, unless the placement expires prior to that date.

Dependents in the Armed Forces

No person will be considered a dependent while they are an active duty member of the armed forces of any country.

Incapacitated Children

If your enrolled dependent is an incapacitated child, your coverage for this child will continue beyond age 26 as long as (1) he or she continues to be incapacitated and (2) coverage does not terminate for any other reason. Your child will be considered incapacitated if he or she is unable to earn his or her own living because of a mental or physical impairment and he or she depends chiefly on you for support and maintenance. The disability must have occurred before the end of the month in which the dependent turns age 26. Contact the MI HR Service Center for additional information on the continuation of coverage. Proof that your child is incapacitated may be required periodically.

Dual Enrollment

No person may be covered as both an "employee" and "dependent", nor as a dependent child of more than one employee. If you and your spouse are both employed by the State of Michigan, dental coverage may be carried separately or as one enrollment with dependent coverage.

Your children may NOT be listed on both your and your spouse's (or your and your ex-spouse's) State Preventive Dental Plan if you maintain separate enrollments.

Should you or your spouse separate from State service, take a leave of absence, or become laid off, the departing employee may be enrolled as a dependent on the remaining employee's State Preventive Dental Plan providing the remaining employee:

- was covered as a dependent of the departing employee or was enrolled separately as an employee; and
- continues to meet the eligibility requirements.

Once you return to work, you must wait until the State's next Open Enrollment period before you may transfer your coverage back into your own name.

Applying for Coverage

You may apply for dental care coverage when you meet State Preventive Dental Plan requirements for eligibility. You may enroll yourself and your eligible dependents within 31 days after your eligibility date by calling the MI-HR Service Center at 877-766-6447.

An eligible employee who is not enrolled but is covered by the enrollment of a spouse or parent may enroll within 31 days after termination of the spouse's or parent's coverage. The effective date of coverage is the pay period begin date in which the coverage is lost.

When your dependents are properly enrolled at the time you enroll, their State Preventive Dental Plan coverage is also effective the same day as yours.

If you do not enroll when newly hired, or if you do not enroll your eligible dependents at that time (or when newly acquired), you will be given other opportunities to enroll or add to your enrollment during Open Enrollment periods or in the event of a "family status change" (described in the Family Status Change section).

Family Status Change

Mid-year changes in your enrollment will be allowed during the Plan Year based on what the Internal Revenue Service (IRS) calls a "family status change." These changes occur if you lose or need coverage because:

- you get married or divorced;
- a child is born or adopted;
- you gain legal guardianship of a child;
- your spouse begins or ends employment;

- your spouse changes from part-time to full-time (or vice versa) or takes an unpaid leave of absence resulting in a significant change in your coverage;
- there is a significant change in your coverage (or your spouse's coverage) through your spouse's (non-State of Michigan) employer plan.

If you wish to enroll a newly acquired dependent after your coverage becomes effective, or if another family status change occurs, notify the MI HR Service Center at 877-766-6447 within 31 days. **If you fail to enroll a newly acquired dependent within 31 days of acquiring that dependent, you will have an opportunity to add to your enrollment during the next Open Enrollment period.**

The coverage effective date for a newly acquired dependent will be the date he or she is acquired (by birth, adoption, or legal guardianship). The effective date for a divorce is the actual date of divorce. The effective date for marriage will be the first day of the pay period following the notification and enrollment.

Transfer to Another State Agency or Employee Bargaining Unit

If you transfer from one State agency to another, your existing enrollment will be transferred automatically to the new agency without interruption. If you transfer from one employee bargaining unit to another, your enrollment will be transferred automatically.

Open Enrollment Period

If you are not already enrolled, you may register to enroll during an announced Open Enrollment period. If you are already enrolled, you may change your existing enrollment to include eligible dependents. The effective date of your enrollment or change will be as prescribed in the Open Enrollment materials.

Cancellation of Coverage

Employees

An election may be revoked or changed at any time if the change is the result of a change in family status as defined under Internal Revenue Code Section 125. The cancellation effective date will be the last day of the last payroll period in which a premium is paid.

Your coverage under the State Preventive Dental Plan will automatically terminate (except as explained under "Continuation of Coverage") in the event of the following, whichever occurs first:

- when your employment terminates;
- when you are no longer in an eligible classification of employees;
- on the last day of the last payroll period for which you made a required premium contribution; or
- when the entire group contract is discontinued.

Dependents

An election may be revoked or changed at any time if the change is the result of a change in family status as defined under Internal Revenue Code Section 125. The cancellation effective date will be the last day of the last payroll period in which a dependent contribution is paid. In the event of divorce, the spouse's cancellation effective date will be the date of divorce.

Your dependent's coverage will automatically terminate (except as explained under "Continuation of Coverage") in the event of the following, whichever occurs first:

- when your dependent becomes eligible for coverage as an employee;
- when your coverage terminates;
- when your dependent no longer meets the definition of an eligible dependent (**note**: ex-spouses are not eligible);
- on the last day of the last payroll period for which you made any required dependent premium contribution; or
- when the entire group and/or the group dependent contract is discontinued.

Loss of Eligibility During Treatment

If you or your eligible dependent loses eligibility while receiving dental treatment, only Covered Services received while you or your eligible dependent were covered under the Plan will be payable.

Certain procedures begun before the loss of eligibility may be covered if they are completed within a 60-day period measured from the date of loss of eligibility. In those cases, Delta Dental evaluates those services in progress to determine what portion, if any, is payable by the State Preventive Dental Plan through Delta Dental. The balance of the total fee is your responsibility.

Continuation of Coverage

When your enrollment or your dependent's enrollment in the State Preventive Dental Plan has been cancelled, you or your dependent may be eligible for the continuation of benefits as explained below.

Retirement

If you retire any time prior to the end of the month with a pension beginning the first of the next month, coverage as an active employee is automatically continued to the end of the month.

Death of Employee

In the event of your death, State Preventive Dental Plan coverage will automatically continue for your dependent if he or she will receive an immediate monthly pension benefit from the State of Michigan.

If your dependent is not going to receive a monthly pension benefit following your death, coverage will end 30 days following

your death unless your dependent continues State Preventive Dental Plan coverage pursuant to Federal COBRA regulations. (See "COBRA Continuation").

COBRA Continuation

You and your enrolled dependents may continue terminated State Preventive Dental Plan coverage for up to 18 months by paying the full monthly premium (including the share that is paid by the State) directly to the State if coverage is terminated because of either the employee's suspension or reduction in the employee's work hours (including a PT/PI "furlough"), or the employee's termination from employment (including deferred retirement), unless the termination was for gross misconduct.

Enrolled dependents may also continue State Preventive Dental Plan coverage for up to 36 months by paying the full monthly premium (including the share that is paid by the State) directly to the State. Dependents may continue coverage if the coverage is terminated as a result of the employee's death, divorce, or legal separation (if the legal separation caused the loss of coverage).

COBRA Notification and Application

You or a family member must notify the MI HR Service Center when a divorce occurs or when a dependent child is no longer eligible. For all other qualifying events, your personnel office will notify you and your enrolled family members of your right to continue terminated coverage.

In any case, you (or your dependents) must apply for the continuation of terminated coverage no later than 60 days from the date of your qualifying event or the date coverage ended, whichever is later. This continuation opportunity will end if an application is not submitted or the full COBRA premium is not paid within the stated time limits.

While the Employee is on a Layoff

If you are an employee on a layoff, you may continue terminated State Preventive Dental Plan coverage for yourself and your enrolled dependents for up to 18 months by paying the full monthly premium (including the share that is paid by the State) directly to the State. You can elect to pre-pay the "employee's share" of the biweekly premium covering the first two pay periods after the layoff by having the premiums deducted from your last paycheck. The State will then contribute the "State's share." This four-week "prepaid period" will not extend the 36-month time period allowed for the continuation of active coverage.

While the Employee is on a Leave of Absence

If you are an employee on a leave of absence, you may continue terminated State Preventive Dental Plan coverage for you and your dependents for up to 18 months by paying the full monthly premium (including the share that is paid by the State) directly to the State.

II. Summary of Benefits

Enrolled employees and covered dependents are entitled to those covered dental services listed below to the extent specified in bargaining unit contracts or the Compensation Plan and summarized in the State of Michigan Summary of Benefits.

Diagnostic & Preventive Services

Diagnostic Services – 100%*

Services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease. Covered Services include oral examinations limited to twice in a Plan Year.

Preventive Services – 100%*

Services and procedures to prevent dental abnormalities or disease. Covered Services include:

- three prophylaxes (teeth cleanings), including periodontal prophylaxes, in a Plan Year;
- two fluoride treatments for enrolled dependents under age 19, in a Plan Year; and
- space maintainers for enrolled dependents under age 14.

Brush Biopsy – 100%*

Oral brush biopsy procedure and laboratory analysis used 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.

Radiographs – 100%*

X-rays as required for routine care or as necessary for the diagnosis of a specific condition. Covered Services include full mouth X-rays once every five years, and bitewing X-rays no more than once in a Plan Year unless special need is shown.

* In the event that you seek treatment from a dentist who does not participate in any of Delta Dental's programs, you may be responsible for more than the percentage indicated above.

III. Selecting a Dentist

The State Dental Plan provides you the opportunity to see any provider you choose, regardless of whether that provider participates in Delta Dental's networks. While you can visit any provider, you will save the most money by visiting a dentist from one of two provider networks: Delta Dental PPO and Delta Dental Premier.

The difference between the two networks is that you will receive greater savings when you receive care from a Delta Dental PPO network provider. This is because providers who participate in the Delta Dental PPO network agree to accept the lowest fees as payment in full. If you choose to visit a Delta Dental Premier® provider, you will still receive the same protections and coverage as you would with a Delta Dental PPO provider, but it may cost more, as the Delta Dental Premier providers accept a different fee schedule as payment in full.

If you see a dentist who does not participate in either the Delta Dental PPO or Delta Dental Premier network, you will still be covered, but you may have to pay more. In this case, Delta

Dental would pay you directly based on the dentist's submitted fee or Delta Dental's nonparticipating dentist fee, whichever is less. You would be responsible for paying the dentist whatever he or she charges, and you may have to submit your own claims.

A list of Participating Dentists will be provided upon request. Although this list is accurate as of the date printed on it, changes may occur. To verify that a Dentist is a Participating Dentist, you can use Delta Dental's online Dentist Directory at DeltaDentalMI.com or call 800-524-0150.

IV. Accessing Your Benefits

To utilize your dental benefits, follow these steps:

1. Please read this benefit booklet carefully so you are familiar with your benefits, payment methods, and terms of this Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits with Delta Dental. If your Dentist is not familiar with This Plan or has any questions, have him or her contact Delta Dental by writing to Delta Dental, Attention: Customer Service, P.O. Box 9089, Farmington Hills, Michigan 48333-9089, or calling the toll-free number at 800-524-0150.
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 dental claims for you.

Mail claims and completed information requests to:

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

Pre-Treatment Estimate

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

Written Notice of Claim and Time of Payment

Because the amount of your Benefits is not conditioned on a Pre-Treatment Estimate decision by Delta Dental, all claims under This Plan are Post-Service Claims. All claims for Benefits must be filed with Delta Dental within one year of the date the services were completed. Once a claim is filed, Delta Dental will determine coverage within 30 days of receiving it. If there is not enough information to determine claim coverage, 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 determine coverage, and (d) inform you or your Dentist that the information must be received within 45 days or your claim will be Denied if the services were performed by a Nonparticipating Dentist, or not chargeable to the Member if the services were performed by a Participating Dentist. You will receive a copy of any notice sent to your Dentist. Once Delta Dental receives the requested information, it has 15 days to determine coverage. If you or your Dentist does not supply the requested information, Delta Dental will deny your claim. In such case, you will be responsible for all charges if the services were performed by a Nonparticipating Dentist. If the services were performed by a Participating Dentist, the services will not be chargeable to the Member. Once Delta Dental determines coverage, it will notify you within five days.

Authorized Representative

You may also appoint an authorized representative to deal with Delta Dental on your behalf with respect to any claim you file or any review of a Denied claim you wish to pursue (see the Claims Appeal Procedure section). Call Delta Dental's Customer Service department, toll-free, at 800-524-0150, or write them at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089, to request a form to designate the person you wish to appoint as your representative. Delta Dental will only recognize the person whom you have authorized on the last dated form filed with Delta Dental. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not inform you of the status of your claim. You will have to get that information from your representative. If you have not designated a representative, Delta Dental will communicate directly with you.

Questions and Assistance

Questions regarding your coverage should be directed to Delta Dental's Customer Service department, toll-free, at 800-524-0150. You may also write to Delta Dental's Customer Service department at 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

1. If your Dentist is a Delta Dental PPO Dentist and a Delta Dental Premier Dentist, Delta Dental will base payment on the lesser of:

   a. The Submitted Amount;

   b. The Delta Dental PPO Dentist Schedule; or

   c. The Maximum Approved Fee

   Delta Dental will send payment to your Delta Dental PPO Dentist, and you will be responsible for any difference between Delta Dental's payment and the Delta Dental PPO Dentist Schedule or the Maximum Approved Fee for Covered Services. You will be responsible for the lesser of the Delta Dental PPO Schedule Amount, the Maximum Approved Fee, or your Dentist's Submitted Amount for most commonly-performed non-covered services. For other non-covered services, you will be responsible for your Dentist's Submitted Amount.

2. If your Dentist is a Delta Dental PPO Dentist but is not a Delta Dental Premier Dentist, Delta Dental will base payment on the lesser of:

   a. The Submitted Amount; or

   b. The Delta Dental PPO Dentist Schedule.

   Delta Dental will send payment to your Delta Dental PPO Dentist, and you will be responsible for any difference between Delta Dental's payment and the Delta Dental PPO Dentist Schedule for Covered Services. You will be responsible for the lesser of the Delta Dental PPO Schedule Amount or your Dentist's Submitted Amount for most commonly-performed non-covered services. For other non-covered services, you will be responsible for your Dentist's Submitted Amount.

3. If your Dentist is not a Delta Dental PPO Dentist but is a Delta Dental Premier Dentist, Delta Dental will base payment on the lesser of:

   a. The Submitted Amount; or

   b. The Maximum Approved Fee.

   Delta Dental will send payment to your Delta Dental Premier Dentist, and you will be responsible for any difference between Delta Dental's payment and the Maximum Approved Fee for Covered Services. You will be responsible for the lesser of the Maximum Approved Fee or your Dentist's Submitted Amount for most commonly-performed non-covered services. For other non-covered services, you will be responsible for your Dentist's Submitted Amount.

4. If your Dentist does not participate in Delta Dental PPO or Delta Dental Premier, Delta Dental will base payment on the lesser of:

   a. The Submitted Amount; or

   b. The Nonparticipating Dentist Fee.

   Delta Dental will usually send payment to you, and you will be responsible for making payment to your Dentist. You will be responsible for any difference between Delta Dental's payment and your Dentist's Submitted Amount.

5. For dental services rendered by an Out-of-Country Dentist, Delta Dental will base payment on the lesser of:

   a. The Submitted Amount; or

   b. The Out-of-Country Dentist Fee.

Delta Dental will usually send payment to you, and you will be responsible for making payment to your Dentist. You will be responsible for any difference between Delta Dental's payment and your Dentist's Submitted Amount.

VI. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies. All charges for the following services will be your responsibility (though your payment obligation may be satisfied by insurance or some other arrangement for which you are eligible):

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX of the Social Security Act; that is, Medicaid.
2. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations, with the exception of congenitally missing teeth.
3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
4. Services completed or appliances completed before a person became eligible under This Plan.
5. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
6. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
7. Charges for hospitalization, laboratory tests, histopathological examinations, and miscellaneous tests.
8. Charges for failure to keep a scheduled visit with the Dentist.
9. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
10. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.

11. Services or supplies, as determined by Delta Dental, which are specialized procedures or techniques.
12. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the supervision of a licensed Dentist. Treatment rendered by any other licensed dental professional, may be covered only as solely determined by the Contractor and/or Delta Dental.
13. 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.
14. Services or supplies received due to an act of war, declared or undeclared, or terrorism.
15. Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
16. Caries preventive medicament.
17. Services or supplies that are not within the categories of Benefits selected by the State of Michigan and that are not covered under the terms of this Certificate.
18. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
19. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, immunization counseling, home care medicaments, etc.).
20. Sealants.
21. Space maintainers for maintaining space due to premature loss of anterior primary teeth.
22. Lost, missing, or stolen appliances of any type or replacement or repair of orthodontic appliances or space maintainers.
23. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
24. Veneers.
25. Prefabricated crowns used as final restorations on permanent teeth.
26. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting.
27. Absent a showing of medical necessity, implant services are not payable for age 18 and under.
28. Nerve dissection.
29. Administration of neuromodulators.
30. Administration of dermal fillers.
31. Application of hydroxyapatite medicament.
32. Paste-type root canal fillings on permanent teeth.
33. Replacement, repair, relines, or adjustments of occlusal guards.
34. Chemical curettage.
35. Services associated with overdentures.
36. Metal bases on removable prostheses.
37. The replacement of teeth beyond the normal complement of teeth.
38. Personalization or characterization of any service or appliance.
39. Temporary crowns used for temporization during crown or bridge fabrication.
40. Posterior bridges in conjunction with partial dentures in the same arch, sharing at least one posterior edentulous space in common.
41. Precision abutments, attachments and stress breakers.
42. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
43. Indexing for osteotomy using dynamic robotic assisted or dynamic navigation.
44. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint.
45. Diagnostic photographs and cephalometric films.
46. 3-D facial scans and images, and printings of such scans and images.
47. Myofunctional therapy.
48. Mounted case analyses.
49. Palliative treatment.
50. Minor and Major Restorative Services.
51. Endodontic Services.
52. Extractions.
53. Oral Surgery Services.
54. Periodontal Services except periodontal prophylaxis.
55. Prosthodontic Services.
56. Orthodontic Services.
57. Molecular, antigen, or antibody testing for a public health related pathogen.
58. Vaccinations.
59. Bone replacement grafts when performed in conjunction with a hemisection.
60. Fabrication, adjustment, reline, or repair of sleep apnea appliances.
61. The administration of a home sleep apnea test, or screening for sleep apnea related breathing disorders.
62. Sleep apnea services.
63. Fabrication, delivery, or titration of oral appliance therapy (OAT) morning repositioning device.
64. Fabrication and placement of a custom removable clear plastic temporary aesthetic appliance.
65. Removal of non-resorbable barrier.
66. Intraoral tomosynthesis images.
67. Direct to consumer orthodontic services and/or supplies, unless Delta Dental has received a Delta Dental-approved

and signed treating dentist attestation form from a Dentist licensed in the state where the Member resides.

68. Any and all taxes applicable to the services.
69. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

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 are your responsibility:

1. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
2. The completion of forms or submission of claims.
3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
4. Local anesthesia.
5. Caries risk assessment performed on a Member age 2 or under.
6. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
7. Infection control.
8. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the condition.
9. Post-operative X-rays, when done following any completed service or procedure.
10. Periodontal charting.
11. Removal of an indirect restoration on a natural tooth.
12. Excavation of a tooth resulting in the determination of non-restorability.
13. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
14. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
15. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.
16. Full mouth debridement when done within 30 days of scaling and root planing.
17. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
18. Scaling and debridement in the presence of inflammation or mucositis of a single implant, when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planing, periodontal surgery or debridement of a peri-implant defect.
19. Full mouth debridement, when done on the same day as a comprehensive periodontal evaluation.
20. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as a sealant, sealant repair, preventive resin restoration or interim caries arresting medicament performed on the same tooth.
21. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
22. Reline, rebase, or any adjustment or repair within six months of the delivery of a denture.
23. Reline or any adjustment or repair to a sleep apnea appliance within six months of the delivery.
24. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
25. Reline, rebase, or any adjustment or repair within six months of the delivery of a denture when performed by the same office.
26. Repairs for implant/abutment supported prosthesis within six months of the delivery of the prosthesis when performed by the same dentist or dental office.
27. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing full mouth X-rays, as determined solely by Delta Dental.
28. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
29. Capture only images which are not associated with any interpretation or reporting.
30. 3-D intraoral and dental scans.
31. Nerve dissection is not payable when done on the same day as the removal of an impacted tooth-completely bony, with unusual surgical complications.
32. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Limitations

The Benefits for the following services or supplies are limited as follows. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the actual date (i.e., to the day) of the applicable prior dates of services in our records with any Delta Dental Plan or, at the request of your group, any dental plan:

1. Bitewing X-rays are payable once per calendar year, unless a full mouth X-ray which includes bitewings has been paid in that same year. Additional X-rays are allowed by a specialist.
2. Panoramic or full mouth X-rays (which may include bitewing X-rays) are payable once in any five-year period. Additional X-rays are allowed by a specialist.

3. Any combination of teeth cleanings (prophylaxes (general or periodontal cleanings),and periodontal maintenance procedures) are payable three times per Calendar Year. Full mouth debridement is payable once in a lifetime.
4. Oral examinations and evaluations (not including limited problem focused evaluations or patient screenings) are only payable twice per Calendar Year, additional evaluations are allowed by a specialist.
5. Patient screening is payable once per Calendar Year, except when performed in conjunction with examinations or evaluations.
6. Preventive fluoride treatments are payable twice per Calendar Year for people under age 19.
7. Bilateral space maintainers are payable once per arch in a lifetime for people age 13 and under.
8. Unilateral space maintainers are payable once per quadrant in a lifetime for people age 13 and under.
9. A distal shoe space maintainer is payable for first permanent molars once per quadrant for people age eight and under.
10. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a claim for those services within one year of the date of service.
11. When services in progress are interrupted, Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.
12. Care terminated due to the death of a Member will be paid to the limit of Delta Dental's liability for the services completed or in progress.
13. Assessments of salivary flow by measurement are payable once in any 36-month period.
14. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

VII. Reconsideration and Claims Appeal Procedure

Reconsideration

If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your claim, you or your Dentist may contact Delta Dental's Customer Service department and ask them to reconsider the claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-524-0150, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your claim. A request for reconsideration is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems or submit an explanation or additional information that might indicate your claim was improperly denied, and allow Delta Dental to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental informally to reconsider its initial determination, you can request a formal review using the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination, you, or your Authorized Representative, should seek a review as soon as possible, but **you must file your request for review within 180 days** of the date that you received that Adverse Benefit Determination. To request a formal review of your claim, send your request in writing to:

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

Please include your name and address, the Subscriber's Member ID, the reason why you believe your claim was wrongly denied, and any other information you believe supports your claim. You also have the right to review the contract between Delta Dental and your employer or organization and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

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

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

The reviewer will make a determination within 60 days of receipt of your request. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of

an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for dental claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your claim free of charge. This notice will also contain a description of any additional materials necessary to complete your claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

The Adverse Benefit Determination notice will inform you of your right to a managerial-level conference to complete the formal grievance procedure. If your claim is denied in whole or in part after you have completed this required Claims Appeal Procedure, or Delta Dental fails to comply with any of the deadlines contained therein, you may request an external review. You must do so within 127 days of the date you received our final determination. Mail your request for an external review to:

Department of Insurance and Financial Services
Office of Appeals and Market Regulation –
Appeals Section
PO Box 30220
Lansing, MI 48909-7720

Fax: 517-284-8838

Email: DIFS-HealthAppeal@michigan.gov

VIII. General Conditions

Coordination of Benefits (Dual Coverage)

This coordination of benefits provision is designed to provide maximum coverage, but not to exceed 100 percent of the total fee for a given treatment plan.

Please note, for married State of Michigan employees who are both enrolled in any of the State Dental Plans, there is no coordination of benefits. Coordination of benefits is available between the State Dental Plans and any other group dental plan.

The primary dental program (as specified below) will pay all of the benefits it would owe as if no other coverage was involved. The secondary program will then pay all of the benefits it would owe as if no other coverage was involved, up to 100 percent of the subscriber's liability under that plan. In no case is any program required to pay more than it would have paid without any coordination of benefits.

The program covering the patient as an "employee" is primary over the program covering the patient as a "dependent."

If a dependent child is covered by both parents, the plan covering the parent whose birthday occurs earliest in the calendar year is primary over the other parent's plan. This birthday rule does not apply when the parents are divorced or legally separated, unless the specific terms of the court decree state that the parents will share custody without stating that one parent is responsible for the dental care expenses of the child. In cases where a court decree designates financial responsibility to one parent, the order of benefits determination is outlined below.

In the case of an enrolled dependent child of divorced or legally separated parents, claims will be paid in the following order of priority:

1. The plan covering the child as a dependent of the parent who, under the terms of a divorce decree, has the responsibility for the dental care of the child. In no event will a child be eligible for enrollment unless he or she meets the criteria in the Eligibility section.
2. The plan covering the child as a dependent of the custodial parent.
3. The plan covering the child as a dependent of the custodial parent's spouse.
4. The plan covering the child as a dependent of the non-custodial parent.

If you are enrolled as a Subscriber under more than one plan, the plan that has covered you the longest is primary over the other. However, a program that covers the Subscriber as a laid-off or retired employee (or as the dependent of a laid-off or retired employee) will have a lower priority than a plan that does not.

Contact Delta Dental for information on alternative rules that may apply to dental plans issued outside of Michigan.

Assignment

Services and Benefits are for the personal benefit of Members and cannot be transferred or assigned, other than to pay Participating Dentists directly.

Subrogation and Right of Reimbursement

To the extent that This Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you and/or your Dependent has to recover from another party or entity, including but not limited to, that party's insurer, or any other insurer that you or your Dependent may have, which would have been the primary payer if not for the payments made by Delta Dental. This

includes but is not limited to, automobile, home, and other liability insurers, as well as any other group health plans.

To the extent that Delta Dental has a subrogation right, you and/or your Dependent must:

1. Provide Delta Dental with any information necessary to identify any other person, entity or plan that may be obligated to provide payments or benefits for the Covered Services that were paid for by Delta Dental,
2. Cooperate fully in Delta Dental's exercise of its right to subrogation and reimbursement,
3. Not do anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co-payee of any settlement amount),
4. Sign any document that Delta Dental determines is relevant to protect Delta Dental's subrogation and reimbursement rights, and
5. Provide relevant information when requested.

The term "information" includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help Delta Dental enforce its rights. Failure by you or your Dependent to cooperate with Delta Dental may result, at the discretion of Delta Dental, in a reduction of future benefit payments available to you or your Dependent under This Plan of an amount up to the aggregate amount paid by Delta Dental that was subject to Delta Dental's equitable lien, but for which Delta Dental was not reimbursed.

Obtaining and Releasing Information

While you and/or your Dependent(s) are enrolled in This Plan, you and/or your Dependent(s) agree to provide Delta Dental with any information it needs to process claims and administer Benefits for you and/or your Dependent(s). This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship

Members are free to choose any Dentist. Each Dentist is solely responsible for the treatment and/or dental advice provided to the Member, and Delta Dental does not have any liability resulting therefrom.

Loss of Eligibility During Treatment

If a Member loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under This Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within 60 days 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. The difference between Delta Dental's payment and the total fee for those services is your responsibility.

Late Claims Submission

Delta Dental will make no payment for services or supplies if a claim for such has not been received by Delta Dental within one year following the date the services or supplies were completed. In the event that a Participating Provider submits a claim more than one year from the date of service, Delta Dental will deny that portion of the claims that Delta Dental would have paid if the claim had been timely submitted, and such denied portion of the claim will not be chargeable to the Member. However, you will remain responsible for any applicable Deductible and/or Copayment. In the event that a Non-participating Provider submits a claim more than one year from the date of service, Delta Dental will Deny the claim and you may be responsible for the full amount.

Change of Certificate or Contract

No changes to this Certificate, your Summary of Dental Plan Benefits, or the underlying contract are valid unless Delta Dental approves them in writing.

Actions

You cannot bring an action on a legal claim arising out of or related to this Certificate unless you have provided at least 60 days' written to Delta Dental, unless prohibited by applicable state law. In addition, you cannot bring an action more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, whichever is shorter. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Change of Status

You must notify Delta Dental, through the MI HR Service Center at (877) 766-6447, 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.

Right of Recovery Due to Fraud

If Delta Dental pays for 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 your acts or acts of your eligible Dependents, it may recover that payment from you or your eligible Dependents. Delta Dental may recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your eligible Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Governing Law

This Certificate and the underlying group Contract will be governed by and interpreted under the laws of the state of Michigan.

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you or your eligible Dependents than is provided by this Certificate, that law shall control over the language of this Certificate.

IX. Glossary

Anesthesia (General) – The condition, resulting from administration of anesthetics, in which the patient is rendered completely unconscious and completely without conscious pain.

Anesthetic – A drug that produces a loss of feeling or sensation, such as novocaine.

Bitewing – Dental X-ray picture showing a part of either the right or left upper and lower jaw.

Children – Your natural Children, stepchildren, adopted Children, Children by virtue of legal guardianship, or Children who are residing with you during the waiting period for adoption or legal guardianship.

Claim - A request for payment for a Covered Service. Claims are not conditioned upon your seeking advance approval, certification, or authorization to receive payment for any Covered Service.

Control Plan (Delta Dental) – The Delta Dental Plan that contracts with your group. The Control Plan will provide all claims processing, service, and administration for a group. Your Control Plan is Delta Dental of Michigan. 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 State of Michigan Summary of Benefits lists the Covered Services provided by the State Preventive Dental Plan.

Delta Dental – Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation providing dental service 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 (Point-of-Service) – 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 Delta Dental Premier 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.

Dental Hygienist – A person who has been trained to remove tartar and stains from the surface of the teeth and who may provide additional services and information on the prevention of oral disease.

Dental Services – Care and procedures employed by dentists for the diagnosis or treatment of dental disease, injury, or abnormal conditions based on valid dental need according to accepted standards of dental practice.

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

- **Delta Dental PPO Dentist (PPO Dentist)** or Participating Dentist – a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental PPO. Delta Dental PPO Dentists agree to accept Delta Dental's fee determination as payment in full for Covered Services.
- **Delta Dental Premier Dentist (Premier Dentist)** or Participating Dentist – a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental Premier. Delta Dental Premier Dentists agree to accept Delta Dental's fee determination as payment in full for Covered Services.

  Wherever a term of this Certificate differs from your state Delta Dental and its agreement with a Participating Dentist, the agreement in that state with that Dentist will be controlling.
- **Nonparticipating Dentist** – a Dentist who has not signed an agreement with Delta Dental 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.

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

Fluoride – A chemical solution that is applied to the teeth for the purpose of preventing dental decay.

Maximum Approved Fee – A system used by Delta Dental to determine the approved fee for a given procedure for a given Delta Dental Premier 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, irrespective of 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.

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 the Covered Service. In all cases, Delta Dental will make the final determination about what is the Maximum Approved Fee for the Covered Service.

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

Member(s) - Any Subscriber or Dependent with coverage under This Plan.

Nonparticipating Dentist Fee – The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist.

Out-of-Country Dentist Fee – The maximum fee allowed per procedure for services rendered by an Out-of-County Dentist.

Periapical – Pertaining to the area of the tooth around the apex (tip) of the root.

Periodontal Disease – Disease that weakens and destroys the gums, bones, and membranes surrounding the teeth.

Plaque – A sticky substance made up of bacteria, dead tissue cells, and debris that accumulates on the teeth.

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.

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

Pre-Treatment Estimate – An estimate of the costs of Covered Services to be provided. A Dentist may submit his or her treatment plan to Delta Dental before providing services. Delta Dental reviews the treatment plan and advises you and your Dentist of what services are covered by your Plan and what Delta Dental's payments may be. Delta Dental's payment for predetermined services depends on continued eligibility and the annual or lifetime Maximum Payments available under your Plan. You are not required to seek a Pre-Treatment Estimate. You will receive the same benefits under your Plan whether or not a Pre-treatment Estimate is requested. Pre-Treatment Estimate is merely a convenience so that you will know before the dental service is provided how much, if any, of the cost of that service is not covered under your Plan. Since you may be responsible for any cost not covered under your Plan, this is likely to be useful information for you when deciding whether to incur those costs.

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

Prophylaxis – Removal of tartar and stains from the teeth.

Space Maintainers – A fixed or removable appliance to prevent the movement of teeth, usually in children.

State of Michigan Preventive Dental Plan – (State Preventive Dental Plan or Plan) is the self-insured fee-for-service/cost management program that provides dental benefits to enrolled members.

Submitted Amount or Submitted Fee – The fee a Dentist bills to Delta Dental for a specific treatment.

Subscriber – An eligible employee enrolled in the State of Michigan Preventive Dental Plan. A Subscriber may enroll his or her eligible dependents.

Urgent Care Claims – Those potentially life-threatening claims as defined in the U.S. Department of Labor Regulations at 29 CFR 2560.503-1(M)(1)(I). Any such claims that may arise under this dental coverage are not considered to be Pre-Service Claims and are not subject to any Pre-Treatment Estimate requirements.

Any person intending to deceive an insurer who knowingly submits an application or files a claim containing a false or misleading 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. We only accept anti-fraud calls at this number.

ANTI-FRAUD TOLL-FREE HOTLINE:

800-524-0147

CUSTOMER SERVICE

If you have any questions that are not answered in this benefit booklet, or for names of Delta Dental PPO Dentists in your area, please call the Customer Service department at Delta Dental of Michigan:

800-524-0150

Monday through Friday

8:30 a.m. to 8:00 p.m. Eastern Time

This information is also available in alternative accessible formats upon request.

For further information, call the Michigan Relay Center for the hearing impaired:

7-1-1

Or use Delta Dental's online Dentist Directory at:

deltadentalmi.com/SOM

You can easily verify your own benefit, claims and eligibility information online 24 hours a day, seven days a week by visiting deltadentalmi.com/SOM and selecting "Log-in/Register" in the upper corner. The Consumer Toolkit will also allow you to print claim forms and ID cards, search our dentist directories, and read oral health tips.

You may send written inquiries to:

Delta Dental of Michigan
Customer Service
P.O. Box 9089
Farmington Hills, MI 48333-9089

Please include your group name (State of Michigan State Preventive Dental Plan), your group number (8700), the Subscriber's ID number, and your daytime telephone number on any written inquiries.

Form No. 0151M

State of MI Prev

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