DeltaCare® USA

Dental Health Care Program for Eligible Employees and Dependents

Combined Evidence of Coverage and Disclosure Form

CAA22

Provided by:
Delta Dental of California
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703

Administered by:
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023
800-422-4234

deltadentalins.com

EVIDENCE OF COVERAGE

DISCLOSURE FORM

DeltaCare® USA Dental HMO Program

This booklet is a Combined Evidence of Coverage and Disclosure Form ("EOC") for your DeltaCare USA Dental HMO Program ("Program") provided by Delta Dental of California ("Delta Dental"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Delta Dental.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. AS REQUIRED BY THE CALIFORNIA HEALTH & SAFETY CODE, THIS IS TO ADVISE YOU THAT THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY. PERSONS WITH SPECIAL HEALTHCARE NEEDS SHOULD READ THE SECTION ENTITLED "SPECIAL NEEDS".

A STATEMENT DESCRIBING DELTA DENTAL'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a Contract Dentist may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Customer Service at 800-422-4234 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

BENEFITS mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

BILLED FOR THE CHARGE: a bill that provides, at a minimum, an accurate itemization of the premium amounts due, the due dates(s), and the period of time covered by the premium(s).

CONTRACT DENTIST means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

CONTRACT ORTHODONTIST means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

CONTRACT SPECIALIST means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

CONTRACTHOLDER means the organization (employer or other organization) named herein contracting to obtain Benefits.

COPAYMENT means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

DENTIST means a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

ELIGIBLE DEPENDENT means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

ELIGIBLE EMPLOYEE means any employee or group member who is eligible for Benefits as described in this booklet.

EMERGENCY DENTAL CONDITION means dental symptoms and/or pain that are so severe that, without immediate attention by a Dentist, they could reasonably result in any of the following:
- placing the patient's health in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part
- death

EMERGENCY DENTAL SERVICE means a dental screening, examination and evaluation by a Dentist or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Dentist, to determine if an Emergency Dental Condition exists and, if it does, the care, treatment and surgery if within the scope of that person's license necessary to relieve or eliminate the Emergency Dental Condition within the capability of the facility.

ENROLLEE means an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

GRACE PERIOD: the period of at least 30 consecutive days beginning the day the Notice of Start of Grace Period is dated.

NOTICE OF END OF COVERAGE: the notice sent to by US notifying the recipient that the Your coverage has been cancelled.

NOTICE OF START OF GRACE PERIOD: the notice sent by Us that the plan will be terminated unless the premium amount due is received no later than the last day of the Grace Period.

OPEN ENROLLMENT PERIOD means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

OUT-OF-NETWORK means treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits under this Program.

PREAUTHORIZATION means the process by which Delta Dental determines if a procedure or treatment is a referable covered Benefit under the Enrollee's Plan.

SPECIAL HEALTH CARE NEED means a physical or mental impairment, limitation or condition that substantially interferes with an Enrollee's ability to obtain Benefits. Examples of such a Special Health Care Need are 1) the Enrollee's inability to obtain access to the assigned Contract Dentist's facility because of a physical disability and 2) the Enrollee's inability to comply with the Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

SPECIALIST SERVICES mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics

or pediatric dentistry, and which must be preauthorized in writing by Delta Dental.

SPOUSE means a person related to or a partner of the Primary Enrollee:
- as defined and as may be required to be treated as a Spouse by the laws of the state where this Contract is issued and delivered;
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides; and
- as may be recognized by the Contractholder.

TREATMENT IN PROGRESS means any single dental procedure, as defined by the CDT Code, that has been started while the Enrollee was eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not the Enrollee continues to be eligible for Benefits under the DeltaCare USA Plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established, full or partial dentures for which an impression has been taken and orthodontics when bands have been placed and tooth movement has begun.

URGENT DENTAL SERVICES mean medically necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

WE, US or OUR means Delta Dental of California or the Administrator as appropriate.

YOU, YOURS or YOURSELF means the individuals who are receiving dental services.

Eligibility for Benefits

Eligible Employees and Eligible Dependents receive Benefits as soon as they are enrolled in the Program. Subject to cancellation as provided under this Program, enrollment of Eligible Employees and Eligible Dependents is for a minimum period of one year.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Contractholder.

Eligible Dependents become eligible on:
1) the date you are eligible for coverage;

2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include, Primary Enrollee's Spouse (unless legally separated or divorced) and children from birth up to age 26.

Children include natural children, stepchildren, adopted children, and foster children. The dependents of Primary Enrollees are eligible to enroll on the same date that the employee, of whom they are a dependent, becomes a Primary Enrollee. Later-acquired dependents become eligible as soon as they acquire dependent status. However, the Primary Enrollee may delay coverage for young children, under the age of four (4), until the beginning of any Calendar Year immediately following said child's fourth birthday. For coverage to begin on such young children, the eligibility notice and additional Premium payment must be received within 31 days of the beginning of the Calendar Year immediately following said child's fourth birthday.

An overage dependent child may be eligible if:
1) they are incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition;
2) they are chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 60 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a physically or mentally disabling injury, illness or condition.

Dependents in active military service are not eligible. No one may be an Eligible Dependent of more than one Eligible Employee. Medicare eligibility will not affect the eligibility of an Eligible Employee or an Eligible Dependent.

How to use the DeltaCare USA Program - Choice of Contract Dentist

To receive Benefits under the DeltaCare USA Program, You must select a Contract Dentist for both yourself and any Dependent Enrollee from the DeltaCare USA network list of Contract Dentists furnished during the enrollment process. You can also access an online provider directory at deltadentalins.com. Collectively, You and Your Eligible Dependents may select no more than three Contract Dentist facilities. If You fail to select a Contract Dentist

or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign You to a Contract Dentist. You may change Your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that Your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment You will receive a DeltaCare USA membership packet that tells you the effective date of Your Program and the address and telephone number of Your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO THEIR ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED IN WRITING BY DELTA DENTAL, OR FOR EMERGENCY DENTAL SERVICES AS PROVIDED IN *EMERGENCY DENTAL SERVICES*. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If Your assigned Contract Dentist's agreement with Delta Dental terminates, that Contract Dentist will complete 1) a partial or full denture for which final impressions have been taken, and 2) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Continuity of Care

Current Members:
You may have the right to the benefit of completion of care with your terminated Dentist for certain acute dental conditions, serious chronic dental conditions and other specified dental conditions. Please call Customer Service at 800-422-4234 to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your terminated Dentist. We are not required to continue your care with that Dentist if you are not eligible under our policy or

if we cannot reach agreement with your terminated Dentist on the terms regarding your care in accordance with California law.

New Members:
You may have the right to the qualified benefit of completion of care with an Out-of-Network Dentist for certain specified dental conditions. Please call the Customer Service department at 800-422-4234 to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your current Dentist. We are not required to continue your care with that Dentist if you are not eligible under our policy or if we cannot reach agreement with your Dentist on the terms regarding your care in accordance with California law.

Special Needs

If an Enrollee believes they have a Special Health Care Need, the Enrollee should contact Delta Dental's Customer Service department at 800-422-4234. Delta Dental will confirm that a Special Health Care Need exists, and what arrangements can be made to assist the Enrollee in obtaining such Benefits. Delta Dental will not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Dentist treating persons with Special Health Care Needs.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service department at 800-422-4234.

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice

is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Dental Services

Emergency Dental Services are used for palliative relief, controlling of dental pain and/or stabilizing the patient's condition. The Enrollee's assigned Contract Dentist's facility maintains a 24 hour emergency dental services system, seven days a week. If the Enrollee is experiencing an Emergency Dental Condition, they can call 911 (where available) or obtain Emergency Dental Services from any dental provider without a referral.

After Emergency Dental Services are provided, further non-emergency treatment is usually needed. Non-emergency treatment must be obtained at the Enrollee's assigned Contract Dentist's facility.

The Enrollee is responsible for any Copayment(s) for Emergency Dental Services received. Non-covered procedures will be the Enrollee's financial responsibility and will not be paid by this Plan.

Urgent Dental Services

Inside the Service Area
An Urgent Dental Service requires prompt dental attention but is not an Emergency Dental Condition. If an Enrollee thinks that they may need Urgent Dental Services, the Enrollee can call their Contract Dentist.

Out of Area Urgent Care
If an Enrollee needs Urgent Dental Services due to an unforeseen dental condition or injury, we cover Medically Necessary dental services when prompt attention is required from an Out-of-Network Dentist if all of the following are true:
- The Enrollee receives the Urgent Dental Services from Out-of-Network Dentists while temporarily outside of the Delta Dental Service Area.
- A reasonable person would have believed that the Enrollee's health would seriously deteriorate if they delayed treatment until they returned to the Delta Dental Service Area.

Enrollees do not need prior authorization for out-of-area Urgent Dental Services. The out-of-area Urgent Dental Services an Enrollee receives from Out-of-Network Dentists are covered if the Benefits

would have been covered if the Enrollee had received them from Contract Dentists.

We do not cover follow-up care from Out-of-Network Dentists after the Enrollee no longer needs Urgent Dental Services. To obtain follow-up care from a Contract Dentist, the Enrollee can call their Contract Dentist. The Enrollee is responsible for any Copayment(s) for Urgent Dental Services received.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics or pediatric dentistry must be: 1) referred by your assigned Contract Dentist; and 2) authorized by us. You pay the specified Copayment(s). (Refer to the Schedules attached to this EOC.)

If you require Specialist Services and there is no Contract Specialist to provide these services within 35 miles of your home address, your assigned Contract Dentist must receive Authorization from Delta Dental to refer you to an Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist that are not authorized by Delta Dental will not be covered. Delta Dental will respond in writing to all Authorization requests for Specialist Services within five days of receipt.

If the services of a Contract Orthodontist are needed, please refer to the Schedules attached to this EOC to determine Benefits.

Second Opinion

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your Contract Dentist. Delta Dental may also request that you obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of an Emergency Dental Condition will be authorized or denied in a timely fashion appropriate for the nature of your condition, not to exceed 72 hours after receipt of the request, whenever possible. For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service department at 800-422 4234 or write to Delta Dental.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Delta Dental. Delta Dental will authorize a second opinion by an Out-of-Network provider if an appropriately qualified Contract Dentist is not available. Delta Dental will only pay for a second opinion which Delta Dental has approved or authorized. You will be sent a written notification should Delta Dental decide not to authorize a second opinion. If you disagree with this determination, you may file a grievance with the Plan or with the Department of Managed Health Care. Refer to the Enrollee Complaint Procedure section for more information.

Claims for Reimbursement

Claims for covered Emergency Dental Services or preauthorized Specialist Services should be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Provider Compensation

A Contract Dentist is compensated by Delta Dental through monthly capitation (an amount based on the number of Enrollees assigned to the Dentist), and by Enrollees through required Copayments for treatment received. A Contract Specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Copayment paid by the Enrollee. In no event does Delta Dental pay a Contract Dentist or a specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. By statute, the DeltaCare USA provider contract contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental. Except for the provisions in *Emergency Dental Services*, if you have not received Preauthorization for treatment from an Out-of-Network Dentist, and we fail to pay that Out-of-Network Dentist, you may be liable to that Dentist for the cost of services.

You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number shown on the back cover of this booklet.

Processing Policies

The dental care guidelines for the DeltaCare USA Program explain to Contract Dentists what services are covered under the dental Contract. Contract Dentists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist that fall under the scope of Benefits of the dental Program are provided subject to any Copayments. If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a specialist. An Enrollee may contact Delta Dental's Customer Service department at 800-422-4234 for information regarding the dental care guidelines for DeltaCare USA.

A covered Benefit appropriately provided through teledentistry is covered on the same basis and to the same extent that the covered Benefit is provided through in-person diagnosis, consultation, or treatment.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or Out-of-Network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary will be governed by the rules stated in the Contract.

If this Plan is secondary, it will pay the lesser of:

1) the amount that it would have paid in the absence of any other dental benefit coverage, or
2) the enrollee's total out-of-pocket cost payable under the primary dental benefit plan as long as the benefits are covered under this Plan.

An Enrollee must provide to Delta Dental and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental will, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these

coordination of benefits provisions, and any such reimbursement paid will be deemed to be Benefits under the Contract. Delta Dental will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefit paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Enrollee Claims Complaint Procedure

Delta Dental will provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

Quality Management Department
P.O. Box 6050
Artesia, CA 90703

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Contractholder and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you may file a request for review (a complaint) with Delta Dental for at least 180 days after receipt of the adverse determination. Delta Dental's review will take into account all information, regardless of whether such information was submitted or considered initially. The review will be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, Delta Dental will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental will consult with a Dentist who has appropriate training and experience. If any consulting dentist is involved in the review, the identity of such consulting dentist will be available upon request.

Within 5 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you a written acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a regional dental consultant for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves an Emergency Dental Condition to a patient's dental health, Delta Dental will provide you and the California Department of Managed Health Care written notification regarding the disposition or pending status of the complaint within three days.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care. You may file a complaint with the Department immediately if you are experiencing an Emergency Dental Condition.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 800-422-4234 and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an Emergency Dental Condition, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for Emergency Dental Condition or urgent medical services. The Department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration

(EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Public Policy Participation by Enrollees

Delta Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment program reports and communication from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to: Customer Service department, P.O. Box 1803, Alpharetta, GA 30023.

Prepayment Fees/Premiums

This Program requires premiums to be paid to Us. If You are required to pay all or any portion of the premiums, You will be advised of the amount prior to enrollment and it will be deducted from Your earnings by payroll deduction or You will be requested to pay it directly. The Contractholder will be responsible for sending all payments of premiums to Us except payments you are requested to pay directly. Should You voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before You can re-enroll.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless We provide notice of a change in premiums or Benefits and the Contractholder does not accept the change. All Benefits terminate as of the date that this Program is terminated, You cease to be eligible or such Your enrollment is cancelled. We are not obligated to continue to provide Benefits in such event except for completion of single procedures commenced while coverage was in effect.

Cancellation, Rescission or Non-renewal of Coverage

We may cancel the Contract only:

- upon 30 days' written notice if Contractholder fails to pay premiums in the amount and as required by the Contract;
- upon 60 days' written notice if Contractholder fails to comply with material provisions relating to employer contribution or

group participation rates by the Contractholder or employer of the Contract; or
- upon 60 days' written notice if We demonstrate that the Contractholder committed fraud or an intentional misrepresentation of material fact under the terms of the Contract.

Cancellation of Enrollment due to Non-Payment of Premium

Grace Period
We may cancel the Contract after written notice to the Contractholder if premiums, or a portion of premiums, are not paid by the due date after being billed for the charge. We will provide a Notice of Start of Grace Period to the Contractholder stating a payment delinquency has triggered a Grace Period of 30 days starting the day the Notice of Start of Grace Period is dated. The Contractholder will promptly send or make available a copy of this notice You. Your coverage will continue in effect during day Grace Period.

You are financially responsible for any and all premiums, and any copayments, coinsurance, or deductible amounts, including those incurred for services received during the Grace Period.

A Notice of End of Coverage will be provided to the Contractholder for all cancellations after the date coverage has ended, but no later than five (5) calendar days after the date coverage has ended that includes the following statement: "To learn about new coverage or whether your coverage can be reinstated, contact Us at deltadentalins.com." The Contractholder will promptly send or make available a copy of this notice You. If You lose coverage, You may be financially responsible for the payment of claims incurred.

Cancellation of Enrollment for other than Non-Payment of Premium
For cancellations, rescission and non-renewals for other than for nonpayment of premium, We will provide the Contractholder with a Notice of Cancellation, Rescission or Nonrenewal. The Contractholder will promptly send or make available a copy of this notice You. A Notice of End of Coverage will be provided to the Contractholder for all cancellations after the date coverage has ended, but no later than five (5) calendar days after the date coverage has ended that includes:

- The following statement: "To learn about new coverage or whether your coverage can be reinstated, contact Us at deltadentalins.com".
- Notice as to the availability of the right to request completion of covered services.

If the Contract is terminated for any cause, we are not required to preauthorize services beyond the termination date or to pay for services provided after the termination date, except for services begun while the Contract was in effect or if You have a cancellation grievance pending for reasons other than nonpayment of premium submitted prior to the effective date of Your cancellation, renewal or rescission. Please refer to the following *Grievance Regarding Cancellation, Rescission or Nonrenewal* section as well as the *Continuation of Benefits* sections.

RIGHT TO SUBMIT GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NONRENEWAL OF YOUR PLAN ENROLLMENT, SUBSCRIPTION OR CONTRACT

If You believe Your enrollment has been, or will be, improperly cancelled, rescinded or not renewed You have at least 180 days from the date of the notice You allege to be improper to submit a grievance to Us and/or the Department of Managed Health Care ("DMHC").

For grievances submitted prior to the effective date of the cancellation, rescission or non-renewal, for reasons other than nonpayment of premium, We will continue to provide coverage while the grievance is pending with Us or the DMHC. During the period of continued coverage, You are responsible for paying premiums and any and all copayments, coinsurance, or deductible amounts as required under Your coverage.

Reinstatement of Coverage

If it is determined the cancellation, rescission or nonrenewal, including a cancellation for nonpayment of premium, is improper, Your coverage may be reinstated retroactive to the date of cancellation, rescission or nonrenewal. The Contractholder or if You are responsible for paying Your premium may responsible for the payment of any and all outstanding premium payments accrued from the effective date of the cancellation, rescission or nonrenewal before reinstatement. Any outstanding premium must be paid prior to reinstatement.

OPTION 1 - YOU MAY SUBMIT A GRIEVANCE TO YOUR PLAN.
You may submit online at deltadentalins.com, or

Cancellation - Nonpayment: call 800-765-6003 or write to:

Delta Dental of California
Attn: Correspondence Department
P.O. Box 997330
Sacramento, CA 95899-7330

Cancellation - Rescission or Nonrenewal: call 866-275-1396 or write to:

DeltaCare USA
17871 Park Plaza Drive, Ste. 200
Cerritos, CA 90703

You may want to submit Your grievance to Us first if You believe Your cancellation, recession, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.

We will resolve Your grievance or provide a pending status within three (3) calendar days. If You do not receive a response from Us within three (3) calendar days, or if You are not satisfied in any way with Our response, You may submit a grievance to the DMHC as detailed under Option 2 below.

OPTION 2 - YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DMHC.
You may submit a grievance to the DMHC without first submitting it to Us or after you have received Our decision on Your grievance. Grievances may be submitted to the DMHC online at www.Healthhelp.ca.gov or by mailing your written grievance to:

Help Center
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725

You may contact the DMHC for more information on filing a grievance at:

Phone: 1-888-466-2219
TDD: 1-877-688-9891
Fax: 1-916-255-5241

Continued Coverage Under USERRA

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you are covered by the Contract on the date your USERRA leave of absence begins, you may continue dental coverage for yourself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of:
- 24 months, beginning on the date the leave of absence begins, or;
- the date you fail to return to work within the time required by USERRA.

For USERRA leave that extends beyond 31 days, the premium for continuation of coverage will be the same as for COBRA coverage.

Continuation of Coverage Under COBRA

(Applies to groups with 20 or more Enrollees) . COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for you and your Dependent Enrollees who lose employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information. We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

Continuation of Coverage Under Cal-COBRA *(Applies to groups with 2-19 Enrollees)*

Cal-COBRA (the California Continuation Benefits Replacement Act) provides a way for you and your Dependent Enrollees who lose employer-sponsored group health coverage ("Qualified Beneficiary" to continue coverage for a period of time. We agree to provide the Benefits to Enrollees who elect continued coverage pursuant to this section, provided:

- continuation of coverage is required to be offered under Cal-COBRA;
- Contractholder notifies us, in writing of any employee who has a qualifying event within 30 days of the qualifying event;
- Contractholder notifies us in writing of any Qualified Beneficiaries currently receiving continuation of coverage from a previous plan;
- Contractholder notifies Qualified Beneficiaries currently receiving continuation coverage under another plan, of the Qualified Beneficiary's ability to continue coverage under Delta Dental's

new group benefit plan for the balance of the period the Qualified Beneficiary is eligible for continuation coverage. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later;
- Contractholder notifies the Qualified Beneficiary if of the ability to elect coverage under the Contractholder's new dental plan, if Contractholder terminates Contract and replaces Delta Dental with another dental plan. Said notice shall be provided the later of 30 days prior to termination of Delta Dental's coverage or when the Enrollees are notified;
- Qualified Beneficiary requests the continuation of coverage within the time frame allowed;
- we receive the required premium for the continued coverage; and
- the Contract stays in force.

We do not assume any of the obligations required by Cal-COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under Cal-COBRA.

Organ and Tissue Donation

Donating organs and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital, when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

Non-Discrimination

Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Customer Service Center at 800-422-4234.

If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a Customer Service representative, or by mail.

DeltaCare USA
17871 Park Plaza Drive, Ste. 200
Cerritos, CA 90703
Telephone Number: 800-422-4234
Website Address: deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019; 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Timely Access to Care

Contract Dentists, Contract Orthodontists and Contract Specialists have agreed that waiting times to Enrollees for appointments for care will never be greater than the following time frames:

1) For emergency care, 24 hours a day, 7 day days a week;
2) For any urgent care, 72 hours for appointments consistent with the patient's individual needs;
3) For any non-urgent care, 36 business days; and
4) For any preventative services, 40 business days.

During non-business hours, the Enrollee will have access to their Contract Dentist's answering machine, answering service, cell phone or pager for guidance on what to do and who to contact if the Enrollee is calling due to an emergency or urgent care situation.

If an Enrollee calls our Plan's customer service phone number, a Customer Service Representative will answer the phone within 10 minutes during normal business hours.

Should the Enrollee need interpretation services when scheduling an appointment with any of our Contract Dentist, Contract Orthodontist and Contract Specialist offices, please call 800-422-4234 for assistance.

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2022 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0330	Panoramic radiographic image	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 12 months*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 12 months*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 12 months*	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0704	3-D photographic image - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost

D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost
D0709	Intraoral - complete series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Application of caries arresting medicament - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$25.00
D1516	Space maintainer - fixed - bilateral, maxillary	$25.00
D1517	Space maintainer - fixed - bilateral, mandibular	$25.00
D1520	Space maintainer - removable - unilateral - per quadrant	$25.00
D1526	Space maintainer - removable - bilateral, maxillary	$25.00
D1527	Space maintainer - removable - bilateral, mandibular	$25.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No Cost
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No Cost

D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No Cost
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Cost
D1557	Removal of fixed bilateral space maintainer - maxillary	No Cost
D1558	Removal of fixed bilateral space maintainer - mandibular	No Cost
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$25.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior [7, 9]	Optional
D2392	Resin-based composite - two surfaces, posterior [7, 9]	Optional
D2393	Resin-based composite - three surfaces, posterior [7, 9]	Optional
D2394	Resin-based composite - four or more surfaces, posterior [7, 9]	Optional
D2510	Inlay - metallic - one surface [3, 5]	No Cost
D2520	Inlay - metallic - two surfaces [3, 5]	No Cost
D2530	Inlay - metallic - three or more surfaces [3, 5]	No Cost
D2542	Onlay - metallic - two surfaces [3, 5]	No Cost
D2543	Onlay - metallic - three surfaces [3, 5]	No Cost
D2544	Onlay - metallic - four or more surfaces [3, 5]	No Cost
D2610	Inlay - porcelain/ceramic - one surface [3, 7]	Optional

D2620	Inlay - porcelain/ceramic - two surfaces [3, 7]	Optional
D2630	Inlay - porcelain/ceramic - three or more surfaces [3, 7]	Optional
D2642	Onlay - porcelain/ceramic - two surfaces [3, 7]	Optional
D2643	Onlay - porcelain/ceramic - three surfaces [3, 7]	Optional
D2644	Onlay - porcelain/ceramic - four or more surfaces [3, 7]	Optional
D2650	Inlay - resin-based composite - one surface [3, 7]	Optional
D2651	Inlay - resin-based composite - two surfaces [3, 7]	Optional
D2652	Inlay - resin-based composite - three or more surfaces [3, 7]	Optional
D2662	Onlay - resin-based composite - two surfaces [3, 7]	Optional
D2663	Onlay - resin-based composite - three surfaces [3, 7]	Optional
D2664	Onlay - resin-based composite - four or more surfaces [3, 7]	Optional
D2710	Crown - resin-based composite (indirect) [3, 6]	$50.00
D2712	Crown - 3/4 resin-based composite (indirect) [3, 6]	$50.00
D2720	Crown - resin with high noble metal [3, 5, 6]	$90.00
D2721	Crown - resin with predominantly base metal [3, 6]	$90.00
D2722	Crown - resin with noble metal [3, 6]	$90.00
D2740	Crown - porcelain/ceramic [3, 6]	$90.00
D2750	Crown - porcelain fused to high noble metal [3, 5, 6]	$90.00
D2751	Crown - porcelain fused to predominantly base metal [3, 6]	$90.00
D2752	Crown - porcelain fused to noble metal [3, 6]	$90.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$90.00
D2780	Crown - 3/4 cast high noble metal [3, 5]	$90.00
D2781	Crown - 3/4 cast predominantly base metal [3]	$90.00
D2782	Crown - 3/4 cast noble metal [3]	$90.00
D2790	Crown - full cast high noble metal [3, 5]	$90.00
D2791	Crown - full cast predominantly base metal [3]	$90.00
D2792	Crown - full cast noble metal [3]	$90.00
D2794	Crown - titanium and titanium alloys [3, 5]	$90.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost

D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	No Cost
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$5.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$15.00
D2930	Prefabricated stainless steel crown - primary tooth	$5.00
D2931	Prefabricated stainless steel crown - permanent tooth	$5.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$15.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$15.00
D2940	Protective restoration	$15.00
D2941	Interim therapeutic restoration - primary dentition	$15.00
D2949	Restorative foundation for an indirect restoration	$15.00
D2950	Core buildup, including any pins when required	$15.00
D2951	Pin retention - per tooth, in addition to restoration	$15.00
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation* [5]	$15.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation* [5]	$15.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$15.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$15.00
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework.	$18.00
D2980	Crown repair necessitated by restorative material failure	$15.00
D2981	Inlay repair necessitated by restorative material failure	$15.00
D2982	Onlay repair necessitated by restorative material failure	$15.00
D2983	Veneer repair necessitated by restorative material failure	$15.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999	IV. ENDODONTICS	
D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	$10.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$10.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$10.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration) [1]	$45.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration) [1]	$90.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration) [1]	$135.00
D3331	Treatment of root canal obstruction; non-surgical access [1]	$45.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth [1]	$45.00
D3346	Retreatment of previous root canal therapy - anterior [1]	$65.00
D3347	Retreatment of previous root canal therapy - premolar [1]	$110.00
D3348	Retreatment of previous root canal therapy - molar [1]	$155.00
D3410	Apicoectomy - anterior [1]	$60.00
D3421	Apicoectomy - premolar (first root) [1]	$60.00
D3425	Apicoectomy - molar (first root) [1]	$60.00
D3426	Apicoectomy (each additional root) [1]	No Cost
D3430	Retrograde filling - per root [1]	$60.00
D3450	Root amputation, per root - *not covered in conjunction with a hemisection* [1]	No Cost
D3471	Surgical repair of root resorption - anterior	$60.00
D3472	Surgical repair of root resorption - premolar	$60.00

D3473 Surgical repair of root resorption - molar $60.00

D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior $60.00

D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar $60.00

D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption - molar ... $60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant $125.00

D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant $25.00

D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth $25.00

D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant $125.00

D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant $125.00

D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant $250.00

D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant $250.00

D4341 Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months* $15.00

D4342 Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months* $15.00

D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period* ..... No Cost

D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$15.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$12.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)- Not Covered

D5110	Complete denture - maxillary [4, 8]	$110.00
D5120	Complete denture - mandibular [4, 8]	$110.00
D5130	Immediate denture - maxillary [4, 8]	$125.00
D5140	Immediate denture - mandibular [4, 8]	$125.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) [4, 8]	$125.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) [4, 8]	$125.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) [4, 8]	$125.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) [4, 8]	$125.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$125.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$125.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$125.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$125.00
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) [4, 8]	$175.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) [4, 8]	$175.00

D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$125.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$125.00
D5410	Adjust complete denture - maxillary [8]	$10.00
D5411	Adjust complete denture - mandibular [8]	$10.00
D5421	Adjust partial denture - maxillary [8]	$10.00
D5422	Adjust partial denture - mandibular [8]	$10.00
D5511	Repair broken complete denture base, mandibular	$20.00
D5512	Repair broken complete denture base, maxillary	$20.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$10.00
D5611	Repair resin partial denture base, mandibular	$20.00
D5612	Repair resin partial denture base, maxillary	$20.00
D5621	Repair cast partial framework, mandibular	$20.00
D5622	Repair cast partial framework, maxillary	$20.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$20.00
D5640	Replace broken teeth - per tooth	$10.00
D5650	Add tooth to existing partial denture	$10.00
D5660	Add clasp to existing partial denture - per tooth	$10.00
D5710	Rebase complete maxillary denture [11]	$45.00
D5711	Rebase complete mandibular denture [11]	$45.00
D5720	Rebase maxillary partial denture [11]	$45.00
D5721	Rebase mandibular partial denture [11]	$45.00
D5725	Rebase hybrid prosthesis	$45.00
D5730	Reline complete maxillary denture (chairside) [11]	$20.00
D5731	Reline complete mandibular denture (chairside) [11]	$20.00
D5740	Reline maxillary partial denture (chairside) [11]	$20.00
D5741	Reline mandibular partial denture (chairside) [11]	$20.00
D5750	Reline complete maxillary denture (laboratory) [11]	$45.00
D5751	Reline complete mandibular denture (laboratory) [11]	$45.00
D5760	Reline maxillary partial denture (laboratory) [11]	$45.00
D5761	Reline mandibular partial denture (laboratory) [11]	$45.00
D5765	Soft liner for complete or partial removable denture - indirect	$45.00

D5820	Interim partial denture (including retentive/ clasping materials, rests, and teeth), maxillary *- limited to initial placement of interim partial denture/stayplate to replace extracted anterior teeth during healing* [8]	No Cost
D5821	Interim partial denture (including retentive/ clasping materials, rests, and teeth), mandibular *- limited to initial placement of interim partial denture/stayplate to replace extracted anterior teeth during healing* [8]	No Cost
D5850	Tissue conditioning, maxillary [8, 11]	No Cost
D5851	Tissue conditioning, mandibular [8, 11]	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

D6210	Pontic - cast high noble metal [5, 12]	$90.00
D6211	Pontic - cast predominantly base metal [12]	$90.00
D6212	Pontic - cast noble metal [12]	$90.00
D6240	Pontic - porcelain fused to high noble metal [5, 6, 12]	$90.00
D6241	Pontic - porcelain fused to predominantly base metal [6, 12]	$90.00
D6242	Pontic - porcelain fused to noble metal [6, 12]	$90.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$90.00
D6245	Pontic - porcelain/ceramic [7, 12]	Optional
D6250	Pontic - resin with high noble metal [5, 6, 12]	$90.00
D6251	Pontic - resin with predominantly base metal [6, 12]	$90.00
D6252	Pontic - resin with noble metal [6, 12]	$90.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces [7, 12]	Optional
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces [7, 12]	Optional
D6602	Retainer inlay - cast high noble metal, two surfaces [5, 12]	No Cost
D6603	Retainer inlay - cast high noble metal, three or more surfaces [5, 12]	No Cost

D6604	Retainer inlay - cast predominantly base metal, two surfaces [12]	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces [12]	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces [12]	No Cost
D6607	Retainer inlay - cast noble metal, three or more surfaces [12]	No Cost
D6608	Retainer onlay - porcelain/ceramic, two surfaces [7, 12]	Optional
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces [7, 12]	Optional
D6610	Retainer onlay - cast high noble metal, two surfaces [5, 12]	No Cost
D6611	Retainer onlay - cast high noble metal, three or more surfaces [5, 12]	No Cost
D6612	Retainer onlay - cast predominantly base metal, two surfaces [12]	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces [12]	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces [12]	No Cost
D6615	Retainer onlay - cast noble metal, three or more surfaces [12]	No Cost
D6720	Retainer crown - resin with high noble metal [5, 6, 12]	$90.00
D6721	Retainer crown - resin with predominantly base metal [6, 12]	$90.00
D6722	Retainer crown - resin with noble metal [6, 12]	$90.00
D6740	Retainer crown - porcelain/ceramic [7, 12]	Optional
D6750	Retainer crown - porcelain fused to high noble metal [5, 6, 12]	$90.00
D6751	Retainer crown - porcelain fused to predominantly base metal [6, 12]	$90.00
D6752	Retainer crown - porcelain fused to noble metal [6, 12]	$90.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$90.00
D6780	Retainer crown - 3/4 cast high noble metal [5, 12]	$90.00
D6781	Retainer crown - 3/4 cast predominantly base metal [12]	$90.00
D6782	Retainer crown - 3/4 cast noble metal [12]	$90.00
D6784	Retainer crown - titanium and titanium alloys	$90.00

D6790	Retainer crown - full cast high noble metal [5, 12]	$90.00
D6791	Retainer crown - full cast predominantly base metal [12]	$90.00
D6792	Retainer crown - full cast noble metal [12]	$90.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker [12]	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	$15.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	$3.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$3.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$8.00
D7220	Removal of impacted tooth - soft tissue	$40.00
D7230	Removal of impacted tooth - partially bony	$60.00
D7240	Removal of impacted tooth - completely bony	$80.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$80.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	$80.00
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	$70.00
D7471	Removal of lateral exostosis (maxilla or mandible) .	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost

D7961 Buccal/labial frenectomy (frenulectomy) ..... No Cost

D7962 Lingual frenectomy (frenulectomy) ..... No Cost

D8000-D8999 XI. ORTHODONTICS

D8070 Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* [2] $1,600.00

D8080 Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* [2] $1,600.00

D8090 Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children* [2] $1,800.00

D8660 Pre-orthodontic treatment examination to monitor growth and development - *not to be charged with any other consultation procedure(s)* [10] ..... No Cost

D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)) [13] ..... No Cost

D8681 Removable orthodontic retainer adjustment ..... No Cost

D8999 Unspecified orthodontic procedure, by report - *includes START-UP FEES, (including initial examination, diagnosis, consultation and initial banding)* $350.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110 Palliative (emergency) treatment of dental pain - minor procedure $5.00

D9211 Regional block anesthesia ..... No Cost

D9212 Trigeminal division block anesthesia ..... No Cost

D9215 Local anesthesia in conjunction with operative or surgical procedures ..... No Cost

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia ..... No Cost

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician $10.00

D9311 Consultation with a medical health care professional ..... No Cost

D9430 Office visit for observation (during regularly scheduled hours) - no other services performed $5.00

D9440 Office visit - after regularly scheduled hours $20.00

D9450 Case presentation, detailed and extensive treatment planning ..... No Cost

D9912	Pre-visit patient screening	$0.00
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

Procedures not listed above are not covered; however, may be available at the Contract Dentist's "filed fees".

Procedures with age restrictions will be subject to exceptions based on medical necessity.

FOOTNOTES

1 *A Benefit for permanent teeth only.*

2 *Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 (Start-up fee). Beyond 24 months of active treatment, an additional monthly fee of $75.00 applies.*

3 *Replacement is subject to a limitation requiring the existing restoration to be 5+ years old.*

4 *Replacement is subject to a limitation requiring the existing denture to be 5+ years old.*

5 *Base or noble metal is the benefit. If a crown, pontic, inlay, onlay or indirectly fabricated post and core is made of high noble metal, an additional fee up to $100.00 per tooth will be charged for the upgrade. This charge also applies to a titanium crown.*

6 *Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of $150.00.*

7 *Optional is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the program. The applicable charge to the Enrollee is the difference between the Contract Dentist's "filed fee" for the Optional procedure and the "filed fee" for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are benefits. "Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding the DeltaCare USA Program should be directed to Delta Dental's Customer Service department at 800-422-4234.*

8 *Includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement, if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.*

9 *An amalgam is the Benefit.*

10 *In the event comprehensive orthodontic treatment is not required or is declined by the Enrollee, a fee of $25.00 will apply. The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.*

11 *Limited to 1 per denture during any 12 consecutive months.*

12 *Replacement is subject to a limitation requiring the existing bridge to be 5+ years old.*

13 *Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee of $75.00 applies.*

SCHEDULE B

Limitations and Exclusions below with age restrictions will be subject to exceptions based on medical necessity.

Limitations of Benefits

1. Full mouth x-rays are limited to one set every 24 consecutive months and include any combination of periapicals, bitewings and/or panoramic film.
2. Bitewing x-rays are limited to not more than one series of four films in any six month period.
3. Diagnostic casts are limited to aid in diagnosis by the Contract Dentist for covered Benefits.
4. If a biopsy is prior approved by Us to an oral surgeon, then histopathologic examination of the resulting biopsy specimen is covered and available at no additional cost.
5. Prophylaxis or periodontal maintenance is limited to one procedure each six month period.
6. Benefits for sealants include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars through age nine and second molars through age 15. Benefits for sealants do not include the repair or replacement of a sealant on any tooth within three years of its application.
7. A filling is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
8. A crown is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five year limitation (Limitation #12).
9. A covered metallic inlay, onlay, crown or fixed partial denture (bridge) using base or noble metal is available for listed Copayment(s). If the Enrollee elects to have high noble metal used instead, the maximum additional cost of this material upgrade is $100.00 per tooth or pontic. For a cast post and core, the Benefit is for base or noble metal. If the Enrollee elects to have a high noble metal cast post and core instead, the maximum additional cost of this material upgrade is $100.00 per tooth.

10. For molars, a covered inlay, onlay, crown, or unit of a fixed partial denture (bridge) is metallic without porcelain or other tooth-colored material. If the Enrollee elects to have porcelain, porcelain-fused-to-metal, resin or resin-with-metal used instead, the maximum additional cost for this tooth-colored material upgrade is $150.00 per molar.
11. If a porcelain margin is also chosen by the Enrollee for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is $75.00.
12. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:
    a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**
    b. Either of the following:
        - The existing non-functional restoration/bridge/denture was placed five or more years prior to its replacement, **or**
        - If an existing partial denture is less than five years old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.
13. A direct or indirect pulp cap is a Benefit only on a vital permanent tooth with an open apex or a vital primary tooth.
14. With the exception of pulp caps and pulpotomies, endodontic procedures (e.g. root canal therapy, apicoectomy, retrofill, etc.) are only a Benefit on a permanent tooth.
15. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.
16. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
17. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.
18. Coverage for the placement of a fixed partial denture (bridge) requires that:
    a. No cantilevered posterior pontic (prosthetic tooth) be included; **and**

b. Either of the following:
   - The sole tooth to be replaced in the arch is a permanent tooth, which cannot be replaced by adding another tooth to an existing removable partial denture; **or**
   - The new bridge would replace an existing, non-functional bridge (see Limitation #9); **or**
   - Each abutment tooth to be crowned meets Limitation #8.

19. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.
20. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to:
    - The replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture **or**
    - The replacement of permanent tooth/teeth for children under 16 years of age.
21. Retained primary teeth shall be covered as primary teeth.
22. Excision of the frenum is a Benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.
23. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Us, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
24. In cases of accidental injury, Benefits available are described in *Schedule B, Accident Injury Benefit*. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function, exclusive attrition and normal wear, will be covered as described in *Schedules A, Description of Benefits and Copayments; and B, Limitations and Exclusions of Benefits.*
25. Benefits for a soft tissue management program are limited to those parts which are listed covered services listed in *Schedule A, Description of Benefits and Copayments*. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered Benefits.

26. A new removable partial, complete or immediate denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.

27. An Optional procedure is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Program. The applicable charge to the Enrollee is the difference between the Contract Dentist's "filed fee" for the Optional procedure and the "filed fees" for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are Benefits.

    Optional procedures include:

    - The use of a tooth-colored material when restoring a posterior tooth with a filling, inlay or onlay; and
    - Units in a fixed partial denture (bridge) made of porcelain/ceramic, which is not fused to and supported by underlying cast metal.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Dental conditions arising out of and due to Enrollee's employment for which Workers' Compensation is paid. Services that are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision, except as provided in Section 1373(a) of the California Health and Safety Code.
3. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
6. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, orthodontics.
7. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.), except for the treatment of newborn children with congenital defects or birth abnormalities.
8. Dispensing of drugs not normally supplied in a dental facility.
9. Any procedure that in the professional opinion of the Contract Dentist or Delta Dental's dental consultant:
    a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
    b. is inconsistent with generally accepted standards for dentistry.
10. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized in writing by Us or as cited under *Emergency Services.* To obtain written Authorization, the Enrollee should call Our Customer Service department at 800-422-4234.
11. Consultations for non-covered benefits.

12. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
13. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
14. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.
15. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ).
16. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth construction under the DeltaCare USA Program. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered benefits. This exclusion does not affect any other Benefits.
17. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
18. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions.
19. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.

Orthodontic Limitations

The DeltaCare USA Program provides coverage for orthodontic treatment plans provided through Our Contract Orthodontists. The start-up fees and the cost to the Enrollee for the treatment plan are listed in *Schedule A, Description of Benefits and Copayments* and subject to the following:

1. Orthodontic treatment must be provided by the Contract Orthodontist.
2. Benefits cover 24 months of active comprehensive orthodontic treatment. Included is the initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustment to retainers and office visits for a maximum of two years.
3. Treatment plans extending beyond 24 months of active treatment, or 24 months of the retention phase of treatment will be subject to a monthly office visit fee to the Enrollee not to exceed $75.00 per month.
4. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not Us will be responsible for payment of any balance due for treatment provided after cancellation or termination. In such a case the Enrollee's payment shall be based on a maximum of $2,800.00 for covered dependent children to age 19 and $3,000.00 for covered adults and dependent children to age 26. The amount will be prorated over the number of months to completion of the treatment and, will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the Contract Orthodontist.
5. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation have been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of $25.00 in addition to diagnostic record fees.

6. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are Benefits. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the Contract Orthodontist's usual and customary fee.
7. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the Enrollee's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the Contract Orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same Copayment amounts as for fixed appliances.

Orthodontic Exclusions

1. Pre-, mid- and post-treatment records which include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances.
3. Retreatment of orthodontic cases.
4. Changes in treatment necessitated by accident of any kind.
5. Initial or continuing orthodontic treatment when such treatment would be inconsistent with generally accepted professional standards.
6. Surgical procedures incidental to orthodontic treatment.
7. Myofunctional therapy.
8. Surgical procedures related to cleft palate, micrognathia or macrognathia.
9. Treatment related to temporomandibular joint disturbances.
10. Supplemental appliances not routinely used in typical comprehensive orthodontics.
11. Restorative work caused by orthodontic treatment.
12. Phase I orthodontics, as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.
13. Extractions solely for the purpose of orthodontics.
14. Treatment in progress at inception of eligibility.
15. Composite bands, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
16. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.
17. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Accident Injury Benefit

An accident injury is damage to the hard and soft tissue of the mouth caused directly and independently of all other causes by external forces. Damage to the hard and soft tissue of the mouth from normal chewing function is covered under *Schedule A, Description of Benefits and Copayments*.

We will pay up to 100% of the Contract Dentist's "filed fees," for expenses an Enrollee incurs for an accident injury, less any applicable Copayment(s), up to a Maximum of $1,600.00 in any 12 month period.

Accident injury benefits include the following procedure in addition to those listed in *Schedule A, Description of Benefits and Copayments*.

CODE

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus - includes splinting and/or stabilization.

Payment of Accident Injury Benefits is subject to *Schedule B, Limitations and Exclusions of Benefits*, in addition to the following provisions:

MAXIMUM

Accident Injury Benefits will be provided for each Enrollee up to a maximum of $1,600.00 in any 12 month period.

LIMITATION

Accident Injury Benefits are limited to services provided as a result of an accident which occurred (a) while the Enrollee was covered under the DeltaCare USA Program, or (b) while the Enrollee was covered under another DeltaCare USA Program, and if the benefits for the expenses incurred would have been paid if the Enrollee had remained covered under that Program.

EXCLUSIONS

In addition to *Schedule B*, limitations #13, #15, #20, #21 and #24 and exclusions #1-9, #11-15 and #18-20, the following exclusions apply:

1. Prophylaxis.
2. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
3. Replacement of existing restorations due to decay.

4. Orthodontic services (treatment of malalignment of teeth and/or jaws).
5. Replacement of existing restorations, crowns, bridges, dentures and other dental or orthodontic appliances damaged by accident injury.

"Filed fees" mean the Contract Dentist's fees on file with Us. Questions regarding these fees should be directed to Our Customer Service department at 800-422-4234.

Non-Discrimination Disclosure

Discrimination Is Against the Law

We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. We do not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

Coverage for medically necessary health services are available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. We will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. We will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

DeltaCare USA
PO Box 1803 Alpharetta, GA 30023-1803
1-800-422-4234
deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint

Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

We provide free aids and services to people with disabilities to communicate effectively with us, such as:

- qualified sign language interpreters
- written information in other formats (large print, audio, accessible electronic formats, other formats)

We also provide free language services to people whose primary language is not English, such as:

- qualified interpreters
- information written in other languages

If you need these services, contact our Customer Service department.

Protect your oral health. Prevention is the key to avoiding tooth and gum problems. Brush and floss regularly, and visit the dentist for cleanings and exams. To learn more about prevention and avoiding dental problems, visit **deltadentalins.com**. You'll find oral health articles, videos and other tools and tips for caring for your teeth. Don't forget to sign up for *Grin!*, our free dental health e-magazine.

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您能自行閱讀本文件嗎？如果不能，我們可請人幫助您閱讀。您還可以請人以您的語言撰寫本文件。如需免費幫助，請致電 1-800-422-4234 (TTY: 711)。(Chinese)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 1-800-422-4234 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-800-422-4234 (TTY: 711)번으로 연락하십시오. (Korean)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-800-422-4234 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-800-422-4234 (телетайп: 711). (Russian)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نوفر لك من يساعدك في قراءتها. ربما يمكنك أيضًا الحصول على هذا المستند مكتوبًا بلغتك للمساعدة المجانية اتصل بـ 1-800-422-4234 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-800-422-4234 (TTY: 711). (Haitian Creole)

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