DeltaCare® USA

Dental Health Care Plan

Evidence of Coverage and Disclosure Form

CAA24

Underwritten by:
Delta Dental of California
18000 Studebaker Road, Suite 530
Cerritos, CA 90703

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

deltadentalins.com

Evidence of Coverage and Disclosure Form

Introduction

DeltaCare® USA Dental Health Care Plan

This Combined Evidence of Coverage and Disclosure Form ("EOC") provides information about Your DeltaCare USA Dental Health Care Plan ("Plan") provided by Delta Dental of California ("Company"), on behalf of itself, and its affiliated companies. To offer these Benefits, the Contractholder has entered into a Group Dental Service Contract with Us.

This document, including the Contract and any attachments, provides the terms and conditions of Your Plan's coverage. Read this document carefully for an explanation of Your coverage, including the *Definitions* section for any terms with special or technical meanings.

This Combined EOC and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

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.

PERSONS WITH SPECIAL HEALTHCARE NEEDS SHOULD READ THE SECTION ENTITLED "SPECIAL NEEDS".

Terms such as "You," "Your" and "Yourself" means the individuals who are covered. "We," "Us" and "Our" refers to the Company or Our Third Party Administrator ("Administrator").

Request Confidential Communications
You may request to receive communications about Your protected health information from Us at an alternate address or by an alternate method. If You would like to submit a new request for confidential communications or revise or cancel an existing one, contact Us via: email: departmentriskethicsandcompliance@delta.org, or mail: the address below DeltaCare USA Customer Service, P.O. Box 1803 Alpharetta, GA 30023 or visit Our website deltadentalins.com. Your request will be valid until You cancel the request or submit a new request.

Identification Card (ID)
ID cards are not required to receive dental services. However, when You receive dental services, Your Enrollee identification ("ID") number should be provided to Your Dentist. An ID card will may be obtained by visiting Our website at deltadentalins.com.

Contract
The Benefit explanations contained in this EOC and the attachments are subject to all provisions of the Contract. In the event there is a conflict

between the EOC and the Contract, the Contract prevails. This document is not a Summary Plan Description under the Employee Retirement Income Security Act ("ERISA").

Contact Us
For more information, visit Our website at deltadentalins.com or call the Customer Service at 800-422-4234 or You may submit an inquiry to:

DeltaCare USA Customer Service
P.O. Box 1803
Alpharetta, GA 30023

Notice
Please read the following information so that You will know how to obtain dental services.

You must obtain dental Benefits from Your assigned Contract Dentist or be referred for Specialist Services.

INFORMATION CONCERNING BENEFITS UNDER THE DELTACARE USA PROGRAM

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM AND THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Professional Services	An Enrollee may be required to pay a Copayment amount for each procedure as shown in the *Description of Benefits and Copayments*, subject to the limitations and exclusions. Copayments range by category of service. Examples are as follows: Diagnostic Services No Cost - $ 5.00 Preventive Services No Cost - $ 35.00 Restorative Services $5.00 - $ 150.00 Endodontic Services No Cost - $ 170.00 Periodontic Services No Cost - $ 250.00 Prosthodontic Services No Cost - $ 250.00 Oral and Maxillofacial Surgery No Cost - $ 80.00 Orthodontic Services No Cost - $1800.00 Adjunctive General Services No Cost - $ 20.00 **NOTE:** Some services may not be covered. Certain services may be covered only if provided by specified Dentists, or may be subject to an additional charge. Limitations apply to the frequency with which some services may be obtained. For example: bitewing x-rays are limited to one series of four films in each six month period; replacement of complete dentures, crowns and bridges is limited to once in any five year period.
(D) Outpatient Services	Not Covered
(E) Hospitalization Services	Not Covered
(F) Emergency Dental Coverage	The Enrollee may receive a maximum Benefit of up to $100 per emergency for out-of-area Emergency Services.
(G) Ambulance Services	Not Covered
(H) Prescription Drug Services	Not Covered
(I) Durable Medical Equipment	Not Covered
(J) Mental Health Services	Not Covered
(K) Chemical Dependency Services	Not Covered
(L) Home Health Services	Not Covered
(M) Other	Not Covered

Each individual procedure within each category listed above, and which is covered under the Program has a specific Copayment, which is shown in the *Description of Benefits and Copayments*, in the Combined Evidence of Coverage and Disclosure Form.

Table Of Contents

Definitions

Certain terms used throughout this document begin with capital letters. When these terms are capitalized, use the following definitions to understand their meanings as they pertain to Your benefits and how the dental Plan works.

Authorization: The process by which We determine if a procedure or treatment is a referable Benefit under Your Plan.

Benefits: Dental services provided by Us as described in this EOC, the Contract and Schedules. See also Schedules.

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).

Calendar Year: The 12 months of the year from January 1 through December 31.

Contract Dentist: A Dentist who provides services in general dentistry and who has agreed to provide Benefits under this Plan. Contract Dentists may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services. Referrals for Specialist Services must be obtained from Your Contract Dentist.

Contract Orthodontist: A Dentist who specializes in orthodontics and who has agreed to provide Benefits under this Plan. Services obtained from a Contract Orthodontist must be referred by Your Contract Dentist.

Contract Specialist: A Dentist who provides Specialist Services and who has agreed to provide Benefits under this Plan. Services obtained from a Contract Specialist must be referred by Your Contract Dentist.

Contract Year: Period of twelve (12) months starting on the Contract's Effective Date and or the anniversary of the Effective Date and each subsequent 12 month period thereafter.

Contract Term: The period during which coverage is in effect whether on a Calendar or Contract Year.

Contractholder: The group that enters into or executes this Contract to obtain dental coverage.

Copayment: The amounts set forth in *Schedule A - Description of Benefits and Copayments* that You are responsible to pay the treating Dentist. Copayments must be paid at the time treatment is received.

Dependents ("Dependent Enrollees"): The Primary Enrollee's eligible Dependents and any Individuals eligible to enroll for Benefits because of their relationship with the Primary Enrollee. And includes:

- The Spouse
- dependent children from birth to age 26 regardless of marital status
- as otherwise required by state or federal law.

Children include natural children, stepchildren, foster children, grandchildren, adopted children, children placed for adoption and children of a partner as recognized by the Contractholder.

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

Effective Date: The date the Contract or coverage begins.

Emergency Dental Condition: Means dental symptoms and/or pain that are so severe that, without immediate attention by a Dentist, 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 ("Primary Enrollee"): Employee or an Dependent ("Dependent Enrollee") enrolled to receive Benefits.

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.

Notice of End of Coverage: The notice sent to by Us notifying the recipient that 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: The period the Contractholder has established for You to make changes in coverage selections for the next Contract Term.

Optional Treatment: Any alternative procedure that satisfies the same dental need as a covered procedure and is chosen by You subject to the limitations and exclusions described in the Schedules attached to this EOC.

Out-of-Network: Treatment by a Dentist who has not signed a contract with Us to provide Benefits under this Plan. Also referred to as Non-participating Dentist.

Plan: Dental Benefits selected by the Contractholder and provided under the Contract, EOC and any attachments.

Premium: Payment made in consideration of dental coverage.

Schedules: Dental services and procedures and applicable limitations and exclusions included under Your Plan and described in:

- *Schedule A, Description of Benefits and Copayments,* and
- *Schedule B, Limitations and Exclusions of Benefits*

Schedule A, Description of Benefits and Copayments ("Schedule A"): The Schedule that contains the description of covered Benefits and their Copayments that will be provided to You under this Contract.

Special Health Care Need: Means a physical or mental impairment, limitation or condition that substantially interferes with Your ability to obtain Benefits. Examples of such a Special Health Care Need are 1) the inability to obtain access to Your Contract Dentist's facility because of a physical disability and 2) the inability to comply with

the Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

Specialist Services: Services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics or pediatric dentistry. Specialist Services must be referred by a Contract Dentist.

Spouse: An individual who is 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 the Contract is issued and delivered;
- Defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides; or
- 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 You were eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not You continue 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: Means medically necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

Eligibility and Enrollment - When Coverage Begins

Eligibility Requirements

The Contractholder is responsible for establishing eligibility and reporting enrollment to Us. We process enrollment as reported. You are eligible to enroll if You meet the eligibility requirements defined by the Contractholder.

Eligibility is determined by the Contractholder. We do not make eligibility determinations. We will update Our files to record the eligibility information provided by the Contractholder or its designee.

Your Dependents are eligible to enroll on the same date that You enroll. Later-acquired dependents become eligible as soon as they acquire dependent status.

Eligibility may be delayed for young children, under the age of 4, until the beginning of any Contract Term immediately following the child's birthday. For coverage to begin on young children, the eligibility notice and additional Premium payment must be received by Us within 30 days of the beginning of the Contract Term immediately following the child's birthday.

Children/students must be dependent upon You for support and maintenance.

There is no coverage under this Plan for Dependents on active military duty.

Medicare eligibility will not affect Your eligibility or Your Dependent's eligibility, if applicable.

Overage Children

An overage dependent child may be eligible if:
- The child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition;
- The child is chiefly dependent on the Primary Enrollee for support; and
- Proof of disability is provided within 60 days of request. Proof of disability will not be required more than one (1) time per year following a two (2) year period after the Dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Primary Enrollee for support because of a physically or mentally disabling injury, illness or condition.

Enrollment Requirements
If the Contractholder is responsible for Your Premium, coverage will begin on the Contract's Effective Date.

If You are responsible for Your Premium,
- You must enroll within 31 days after the date You become eligible or during an Open Enrollment Period.
- All Dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period or Special Enrollment Period.
- If You elect Dependent coverage, You must enroll all of Your Dependent Enrollees for coverage.

An exception for enrolling Dependent Enrollees within 30 days after they become eligible applies for certain young children. The

eligibility date for such children may be delayed as outlined in the *Eligibility Requirements* section.

You:

- Must pay Premiums in the manner elected by the Contractholder and approved by Us, and
- May not drop coverage and may only make coverage changes during an Open Enrollment Period or Special Enrollment Period as a result of a qualifying status change.

A Dependent may not be enrolled under more than one Primary Enrollee.

A child who is eligible as a Primary Enrollee and a Dependent can be insured as a Primary Enrollee or as a Dependent Enrollee but not both at the same time.

Special Enrollment Periods - Enrollment Changes
After Your Effective Date, You may change Your enrollment during an Open Enrollment Period or during a Special Enrollment Period as a result of a qualifying status change. Qualifying status changes include, but are not limited to, the following events:

- Marital status (Examples include but are not limited to: marriage, divorce, legal separation, annulment or death);
  - Number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
  - Number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
  - Employment status (change in Your or Your Dependent's employment status;
  - Residence (You move);
  - Court order requiring dependent coverage;
  - Loss of other group coverage;
  - Any other current or future election changes permitted by Internal Revenue Code Section 125; or
  - Any other changes specified by applicable law or regulation.

How to Use the DeltaCare USA Plan

Choice of Contract Dentist
We will provide Your Plan with Contract Dentists at convenient locations. Upon enrollment, You must select a Contract Dentist from

the list of Dentists provided at deltadentalins.com. If the Contract Dentist You selected becomes unavailable, We will request You make a selection to another Contract Dentist. If You fail to select a Contract Dentist, the first Contract Dentist You visit will become Your selected Dentist following Your first routine visit.

You may change Your Contract Dentist online or by contacting the Customer Service at 800-422-4234. Selections made by the 15th of the month are effective immediately. Selections made on or after the 16th of the month will be effective on the first day of the following month.

We will request You select another Contract Dentist provided Your Contract Dentist:
- Is no longer taking further enrollment;
- No longer participates in the Plan; or
- Requests, for good cause, that You or Your Dependents select another Contract Dentist.

Any dental treatment in progress must be completed before You change to another Contract Dentist. For example, dental treatment may include:
- Partial or full dentures for which final impressions have been taken
- All work on any tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Coordination of Care and Referrals
Services for Benefits must be provided by Your Contract Dentist. Specialist Services, obtained from a Contract Orthodontist or Contract Specialist, must be referred by Your Contract Dentist.

We have no obligation or liability with respect to services provided by Out-of-Network Dentists, with the exception of Emergency Services or Specialist Services referred by a Contract Dentist, and authorized by Us. All authorized Specialist Services claims will be paid less any applicable Copayments.

Contract Dentist Termination
If Your Contract Dentist no longer participates in this Plan, the Contract Dentist will complete all treatment in progress as described above.

Upon termination of a Contract Dentist's agreement, We will be liable for the completion of dental treatment begun prior to the

termination of the agreement. For example, the terminating Contract Dentist will complete:

- A partial or full denture for which final impressions have been taken; or
- All work on any tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

If, for any reason, the Contract Dentist is unable to complete treatment, We will make reasonable and appropriate provisions for the completion of dental treatment by another Contract Dentist.

Continuity of Care

Current Enrollees:
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 Enrollees:
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 You believe You have a Special Health Care Need, You should contact Our Customer Service department at 800-422-4234.
We will confirm that a Special Health Care Need exists, and what arrangements can be made to assist You in obtaining such Benefits. We 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 Us with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Our Customer Service department at 800-422-4234.

Benefits, Limitations and Exclusions

This Plan provides Benefits and any applicable Copayments, deductibles, annual maximums and waiting periods as shown in the attached Schedules. Only services, supplies or procedures listed in the Schedules and deemed appropriate by Your Contract Dentist are covered under this Plan. Contract Dentists may provide services directly or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

In order to keep Your Plan affordable, this Plan includes certain cost-sharing features. First, not all dental services or procedures may be included under Your Plan. If the procedure is not listed in the *Schedules*, it is not covered. You will be responsible to pay the Dentist the full charge for any service not included in Your Plan. Certain procedures require You to pay a Copayment. Copayments are listed in the *Schedules* and must be paid directly to the treating Dentist. Any charges for broken appointments and visits after normal visiting hours, if covered, are also listed in the *Schedules*.

Should We fail to pay a Contract Dentist, You will not be liable to that Dentist for any sums owed by Us. If You have not received Authorization 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. For further clarification, see "*Emergency Services*".

Emergency Dental Services

Emergency Dental Services are used for palliative relief, controlling of dental pain and/or stabilizing the patient's condition. Your Contract Dentist's facility maintains a 24 hour emergency dental services system, seven days a week. If You are experiencing an Emergency Dental Condition, 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 Your Contract Dentist's facility.

You are responsible for any Copayment(s) for Emergency Dental Services received. Non-covered procedures will be Your 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 it is not an Emergency Dental Condition. If You believe that You may need Urgent Dental Services, You can call Your Contract Dentist during normal business hours or after hours.

Out of Area Urgent Care
If You need 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:
- You receive Urgent Dental Services from Out-of-Network Dentist while temporarily outside of the Our Service Area.
- A reasonable person would have believed that Your health would seriously deteriorate if treatment is delayed until returning to Our Service Area.

You do not need prior authorization for out-of-area Urgent Dental Services. The out-of-area Urgent Dental Services You receive from Out-of-Network Dentists are covered if the Benefits would have been covered if You had received the Urgent Dental Services from Contract Dentists.

We do not cover follow-up care from Out-of-Network Dentists after You no longer need Urgent Dental Services. To obtain follow-up care from a Contract Dentist, You can call Your Contract Dentist. You are responsible for any Copayment(s) for Urgent Dental Services received.

Specialist Services

Specialist Services for oral surgery, endodontics, orthodontics, periodontics or pediatric dentistry must be referred by Your Contract Dentist.

If You require Specialist Services and there is no Contract Orthodontist or Contract Specialist to provide these services within 35 miles of Your home, the Contract Dentist must receive Authorization from Us to refer You to an Out-of-Network Orthodontist or Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network orthodontist or Out-of-Network specialist that are not authorized by Us are not covered. We will respond in writing to all Authorization requests for Specialist Services within five days of receipt.

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. We 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 Our Customer Service department at 800-422 4234 or write to Us.

Second opinions will be provided at another Contract Dentist s facility, unless otherwise authorized by Us. We will authorize a second opinion by an Out-of-Network provider if an appropriately qualified Contract Dentist is not available. We will only pay for a second opinion which We have approved or authorized. You will be sent a written notification should We 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 Services or Specialist Services should be submitted for payment within 90 days of receiving treatment. Claims must be received within one (1) year of the treatment date. The address for claims submission is:

Claims Department
P.O. Box 1810
Alpharetta, GA 30023

Provider Compensation
A Contract Dentist is compensated by Us 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 Us through an agreed-upon amount for each covered procedure, less the applicable Copayment paid by You. In no event do We 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 You for any sums owed by Us. 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 Us at the toll-free telephone number shown in this booklet.

Teledentistry

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.

Processing Policies

The Schedules explain the services covered under the Plan. Contract Dentists, Contract Orthodontists and Contract Specialists use professional judgment to determine appropriate services for You. Benefits performed by Contract Dentists, Contract Orthodontists and Contract Specialists are provided subject to any Copayments.

You may contact Our Customer Service at 800-422-4234 for information regarding the dental care guidelines for DeltaCare USA.

Coordination of Benefits
If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, Benefits will be coordinated. If this plan is the primary plan, We will not reduce Benefits. If this plan is the secondary plan, We may reduce Benefits so that the total Benefits paid or provided by all plans do not exceed 100% of total allowable expense.

But if this plan is the "secondary" plan, We determine Benefits after those of the primary plan and will pay the lesser of the amount that We would pay in the absence of any other dental benefit coverage or Your total out-of-pocket cost under the primary plan for Benefits covered under Your Plan.

In Order to determine which Plan is primary, We will use the following rules.

- The plan covering You as an employee or Primary Enrollee is primary over a plan covering You as a dependent.
- The plan covering You as an employee is primary over a plan covering You as a dependent; except that if You are also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    * Secondary to the plan covering You as a dependent; and
    * Primary to the plan covering You as other than a dependent (e.g. a retired employee), then the Benefits of the plan covering You as a dependent are determined before those of the plan covering You as other than a dependent.
- Except as stated in the immediate above paragraph, when this plan and another plan cover the same child as a dependent of different persons, referred to as parents:
    * The Benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
    * If both parents have the same birthday, the Benefits of the plan covering one parent longer are determined before those of the plan covering the other parent for a shorter period of time.
    * However, if the other plan has no birthday rule, but has a rule based on the gender of the parent, and as a result, the plans do not agree on the order of Benefits, the rule in the other plan determines the order of Benefits.

- In the case of a dependent child of legally separated or divorced parents, the plan covering the child as a dependent of the parent with legal custody or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the child as a dependent of the parent with out legal custody.
- If there is a court decree establishing financial responsibility for the child's health care expenses, the Benefits of a plan covering the child as a dependent of the parent with financial responsibility will be determined before the Benefits of any other policy covering the child as a dependent child.
- If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the child's health care expenses, the plans covering the child will follow the order of Benefit determination rules outlined above.
- The Benefits of a plan covering You as an employee who is neither laid-off nor retired are determined before those of a plan covering You as a laid-off or retired employee. The same holds true if You are a dependent of a Primary Enrollee as a retiree or an employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- If Your coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination.
    * First, the Benefits of a plan covering the Enrollee as an employee or Primary Enrollee (or the Primary Enrollee's dependent).
    * Second, the Benefits under the continuation coverage.
    * If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- If none of the above rules determines the order of Benefits, the Benefits of the plan covering an employee longer are determined before those of the plan covering that insured person for the shorter term. When determination cannot be made in accordance with the rules above, the Benefits of a plan that is a medical plan covering dental as a Benefit will be primary to a standalone dental plan.

Enrollee Claims Complaint Procedure

We will provide notification when 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, Our policies, procedures or operations, or the quality of dental services performed by a Contract Dentist,

You may call Customer Service at 800-422-4234, or a written complaint may be submitted to:

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

Written complaints must include, at a minimum the following information:

- Patient's name
- Primary Enrollee's name, address, telephone number and identification number
- Contractholder's name
- Treating Dentist's name and location

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim), You must file a request for review, referred to as a complaint, with Us within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered during the initial benefit determination. The review will be conducted by a person other than the individual who made the original benefit determination, or the individual's subordinate. Upon request and free of charge, You will be provided 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 Plan, We 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 made available upon request.

Within 5 business days of the receipt of any complaint, including adverse benefit determinations, the quality management coordinator will provide You an acknowledgment of receipt of the complaint. Certain complaints may require that You be referred to a Dentist for a clinical evaluation of the dental services provided. We will make 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, We will provide You and the California Department of Managed Health Care written notification regarding the disposition or pending status of the complaint a timely fashion

on appropriate for the nature of Your condition, not to exceed 3 days.

If You have completed Our grievance process, or You have been involved in Our 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 dental 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 Your Plan is subject to the 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 Your rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The US Department of Labor may be contacted at:

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue, N.W.
Washington, D.C. 20210

If You believe You need further review of Your claim, You may contact Your CA Department of Managed Care.

Public Policy Participation by Enrollees

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

Prepayment Fees/Premiums

You are required to contribute towards the cost of Your coverage and the cost of Your Dependent's coverage, if applicable.

Renewal and Termination of Benefits

This Plan renews on the anniversary of the Contract unless We provide notice of a change in Premiums or Benefits and the Contractholder does not accept the change. Your Benefits will terminate:

- As of the date that this Plan is terminated,
- You cease to be eligible under the terms of this Plan, or
- Your enrollment is canceled under the terms of this Plan.

We are not obligated to continue to provide Benefits to You or Your Dependents except for completion of dental treatment started when this Plan 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 be 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
18000 Studebaker Road, Suite 530
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

General Provisions

Compliance with Administrative Simplification, Security and Privacy Regulations
The parties will comply in all respects with applicable federal, state and local laws and regulations relating to administrative simplification, security and privacy of individually identifiable Your information including executing any agreements as required by the Health Insurance Portability and Accountability Act of 1996

("HIPAA") and the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"). The parties agree that this Contract will incorporate terms as necessary and as applicable to execute the required agreements (i.e. business associate agreement) to comply with federal regulations issued under the HIPAA and HITECH Act or to comply with any other enacted administrative simplifications, security or privacy laws or regulations.

Conformity With Prevailing Laws
All legal questions about the Contract will be governed by the state where the Contract was entered into and is to be performed. Any part of the Contract which conflicts with state or federal law is hereby amended to conform to the minimum requirements of such laws.

Entire Contract; Changes
This Contract, including the EOC and Attachments, is the entire agreement between the parties. No agent has authority to change or waive any of its provisions. Changes are not valid unless approved by one of Our executive officers.

Incontestability
After this Contract has been in force for 3 years from the Effective Date, no statement made by the Contractholder will be used to void this Contract. No statement by an employee or You with respect to Your insurability will be used to reduce or deny a claim or contest the validity of insurance for You after that person's coverage has been in effect 3 years or more during the Your lifetime.

No claims or loss incurred or disability commencing after 2 years from the date of issue of the Contract will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed prior to the Effective Date of this Contract.

Legal Actions
No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor will an action be brought at all unless brought within 3 years from expiration of the time within which proof of loss is required by the Contract.

Misstatements on Application; Effect
In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the Contract, all

statements made by You will be deemed representations and not warranties. No such statement will be used in defense to a claim, unless it is contained in a written application.

Severability
If any part of the Contract, this EOC, Attachments or an Amendment to any of these documents is found by a court or other authority to be illegal, void or not enforceable, all other portions of these documents will remain in full force and effect.

Strike, Lay-off and Leave of Absence
You will not be covered for any dental services received while on strike, lay-off or leave of absence, other than as required under the Family & Medical Leave Act of 1993 (FMLA) or other applicable state or federal law*.

*Your coverage is not affected if You take a leave of absence under the FMLA or other applicable state or federal law. If You are currently paying any part of the Premium, You may choose to continue coverage. If You do not continue coverage during the leave, coverage may be resumed upon their return to active work as if no interruption occurred.

Important: FMLA does not apply to all organizations, only those that meet certain size guidelines. Refer to Your Human Resources unit for complete information.

Continuation of 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

The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides a way for You to continue coverage for a period of time when employer coverage is lost. COBRA does not apply to all companies, only those that meet certain size guidelines.

See Your Human Resources Department or website 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).

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.

Timely Access to Care

Contract Dentists, Contract Orthodontists and Contract Specialists have agreed that waiting times 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, You 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 You are calling due to an emergency or urgent care situation.

If You contact Our Plan's customer service phone number, a Customer Service Representative will answer the phone within 10 minutes during normal business hours. Should You 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.

Non-Discrimination

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 race, color, national origin, age, disability, or sex.

We:

- Provides free aids and services to people with disabilities to communicate effectively with Us, such as:
  - Qualified sign language interpreter
  - 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 interpreter
  - Information written in other languages

If You need these services, contact Our Customer Service at 800-422-4234.

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
18000 Studebaker Road, Suite 530
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.

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the Contract Dentist subject to the *Limitations and Exclusions* of the Plan. Please refer to *Schedule B* for further clarification of Benefits. **You should discuss all treatment options with Your 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 Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2024 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 - comprehensive 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
D0396	3D printing of a 3D dental surface scan	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
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 - comprehensive 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	$35.00
D1516	Space maintainer - fixed - bilateral, maxillary	$35.00
D1517	Space maintainer - fixed - bilateral, mandibular	$35.00
D1520	Space maintainer - removable - unilateral - per quadrant	$35.00
D1526	Space maintainer - removable - bilateral, maxillary	$35.00
D1527	Space maintainer - removable - bilateral, mandibular	$35.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00

D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00
D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$35.00

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	$10.00
D2150	Amalgam - two surfaces, primary or permanent	$12.00
D2160	Amalgam - three surfaces, primary or permanent	$14.00
D2161	Amalgam - four or more surfaces, primary or permanent	$14.00
D2330	Resin-based composite - one surface, anterior	$15.00
D2331	Resin-based composite - two surfaces, anterior	$15.00
D2332	Resin-based composite - three surfaces, anterior	$15.00
D2335	Resin-based composite - four or more surfaces (anterior)	$17.00
D2390	Resin-based composite crown, anterior	$12.00
D2391	Resin-based composite - one surface, posterior [2, 5]	Optional
D2392	Resin-based composite - two surfaces, posterior [2, 5]	Optional
D2393	Resin-based composite - three surfaces, posterior [2, 5]	Optional
D2394	Resin-based composite - four or more surfaces, posterior [2, 5]	Optional
D2510	Inlay - metallic - one surface [8, 12]	$45.00
D2520	Inlay - metallic - two surfaces [8, 12]	$50.00
D2530	Inlay - metallic - three or more surfaces [8, 12]	$55.00
D2542	Onlay - metallic - two surfaces [8, 12]	$55.00
D2543	Onlay - metallic - three surfaces [8, 12]	$60.00
D2544	Onlay - metallic - four or more surfaces [8, 12]	$65.00
D2610	Inlay - porcelain/ceramic - one surface [2, 8]	Optional
D2620	Inlay - porcelain/ceramic - two surfaces [2, 8]	Optional

D2630	Inlay - porcelain/ceramic - three or more surfaces [2, 8]	Optional
D2642	Onlay - porcelain/ceramic - two surfaces [2, 8]	Optional
D2643	Onlay - porcelain/ceramic - three surfaces [2, 8]	Optional
D2644	Onlay - porcelain/ceramic - four or more surfaces [2, 8]	Optional
D2650	Inlay - resin-based composite - one surface [2, 8]	Optional
D2651	Inlay - resin-based composite - two surfaces [2, 8]	Optional
D2652	Inlay - resin-based composite - three or more surfaces [2, 8]	Optional
D2662	Onlay - resin-based composite - two surfaces [2, 8]	Optional
D2663	Onlay - resin-based composite - three surfaces [2, 8]	Optional
D2664	Onlay - resin-based composite - four or more surfaces [2, 8]	Optional
D2710	Crown - resin-based composite (indirect) [8, 9]	$85.00
D2712	Crown - 3/4 resin-based composite (indirect) [8, 9]	$85.00
D2720	Crown - resin with high noble metal [8, 9, 12]	$150.00
D2721	Crown - resin with predominantly base metal [8, 9]	$150.00
D2722	Crown - resin with noble metal [8, 9]	$150.00
D2740	Crown - porcelain/ceramic [8, 9]	$150.00
D2750	Crown - porcelain fused to high noble metal [8, 9, 12]	$150.00
D2751	Crown - porcelain fused to predominantly base metal [8, 9]	$150.00
D2752	Crown - porcelain fused to noble metal [8, 9]	$150.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$150.00
D2780	Crown - 3/4 cast high noble metal [8, 12]	$150.00
D2781	Crown - 3/4 cast predominantly base metal [8]	$150.00
D2782	Crown - 3/4 cast noble metal [8]	$150.00
D2790	Crown - full cast high noble metal [8, 12]	$150.00
D2791	Crown - full cast predominantly base metal [8]	$150.00
D2792	Crown - full cast noble metal [8]	$150.00
D2794	Crown - titanium and titanium alloys [8, 12]	$150.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00

D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$17.00
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$5.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$25.00
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* .	$25.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$25.00
D2940	Protective restoration	$25.00
D2941	Interim therapeutic restoration - primary dentition .	$25.00
D2949	Restorative foundation for an indirect restoration ..	$25.00
D2950	Core buildup, including any pins when required	$25.00
D2951	Pin retention - per tooth, in addition to restoration .	$25.00
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation* [12]	$25.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation* [12]	$25.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$25.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$25.00
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework.	$30.00
D2976	Band stabilization - per tooth - *limited to once in a lifetime per tooth*	$14.00
D2980	Crown repair necessitated by restorative material failure	$25.00
D2981	Inlay repair necessitated by restorative material failure	$25.00
D2982	Onlay repair necessitated by restorative material failure	$25.00
D2983	Veneer repair necessitated by restorative material failure	$25.00

D2989	Excavation of a tooth resulting in the determination of non-restorability	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00
D2991	Application of hydroxyapatite regeneration medicament - *limited to twice per tooth in a 12 month period*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	$6.00
D3120	Pulp cap - indirect (excluding final restoration)	$6.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$8.00
D3221	Pulpal debridement, primary and permanent teeth	$15.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$8.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$15.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$15.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration) [6]	$50.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration) [6]	$100.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration) [6]	$150.00
D3331	Treatment of root canal obstruction; non-surgical access [6]	$50.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth [6]	$50.00
D3346	Retreatment of previous root canal therapy - anterior [6]	$70.00
D3347	Retreatment of previous root canal therapy - premolar [6]	$120.00
D3348	Retreatment of previous root canal therapy - molar [6]	$170.00
D3410	Apicoectomy - anterior [6]	$60.00
D3421	Apicoectomy - premolar (first root) [6]	$60.00
D3425	Apicoectomy - molar (first root) [6]	$60.00

D3426	Apicoectomy (each additional root) [6]	No Cost
D3430	Retrograde filling - per root [6]	$60.00
D3450	Root amputation, per root - *not covered in conjunction with a hemisection* [6]	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 pre-operative and post-operative 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	No Cost
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*	$25.00

D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$25.00
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 periodontal evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$25.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$20.00
D4921	Gingival irrigation with a medicinal agent - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110	Complete denture - maxillary [10, 13]	$200.00
D5120	Complete denture - mandibular [10, 13]	$200.00
D5130	Immediate denture - maxillary [10, 13]	$225.00
D5140	Immediate denture - mandibular [10, 13]	$225.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) [10, 13]	$200.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) [10, 13]	$200.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth) [10, 13]	$200.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth) [10, 13]	$200.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$200.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$200.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$200.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$200.00

D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery [10, 13]	$250.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) [10, 13]	$250.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$200.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$200.00
D5410	Adjust complete denture - maxillary [10]	$10.00
D5411	Adjust complete denture - mandibular [10]	$10.00
D5421	Adjust partial denture - maxillary [10]	$10.00
D5422	Adjust partial denture - mandibular [10]	$10.00
D5511	Repair broken complete denture base, mandibular	$25.00
D5512	Repair broken complete denture base, maxillary	$25.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$15.00
D5611	Repair resin partial denture base, mandibular	$25.00
D5612	Repair resin partial denture base, maxillary	$25.00
D5621	Repair cast partial framework, mandibular	$25.00
D5622	Repair cast partial framework, maxillary	$25.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$25.00
D5640	Replace broken teeth - per tooth	$15.00
D5650	Add tooth to existing partial denture	$15.00
D5660	Add clasp to existing partial denture - per tooth	$15.00
D5710	Rebase complete maxillary denture [1]	$60.00
D5711	Rebase complete mandibular denture [1]	$60.00
D5720	Rebase maxillary partial denture [1]	$60.00
D5721	Rebase mandibular partial denture [1]	$60.00
D5725	Rebase hybrid prosthesis	$60.00
D5730	Reline complete maxillary denture (chairside) [1]	$25.00
D5731	Reline complete mandibular denture (chairside) [1]	$25.00
D5740	Reline maxillary partial denture (chairside) [1]	$25.00
D5741	Reline mandibular partial denture (chairside) [1]	$25.00

D5750	Reline complete maxillary denture (laboratory) [1]	$60.00
D5751	Reline complete mandibular denture (laboratory) [1]	$60.00
D5760	Reline maxillary partial denture (laboratory) [1]	$60.00
D5761	Reline mandibular partial denture (laboratory) [1]	$60.00
D5765	Soft liner for complete or partial removable denture - indirect	$60.00
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* [10]	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* [10]	No Cost
D5850	Tissue conditioning, maxillary [1, 10]	$20.00
D5851	Tissue conditioning, mandibular [1, 10]	$20.00

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 [7, 12]	$150.00
D6211	Pontic - cast predominantly base metal [7]	$150.00
D6212	Pontic - cast noble metal [7]	$150.00
D6240	Pontic - porcelain fused to high noble metal [7, 9, 12]	$150.00
D6241	Pontic - porcelain fused to predominantly base metal [7, 9]	$150.00
D6242	Pontic - porcelain fused to noble metal [7, 9]	$150.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$150.00
D6245	Pontic - porcelain/ceramic [2, 7]	Optional
D6250	Pontic - resin with high noble metal [7, 9, 12]	$150.00
D6251	Pontic - resin with predominantly base metal [7, 9]	$150.00
D6252	Pontic - resin with noble metal [7, 9]	$150.00

D6600	Retainer inlay - porcelain/ceramic, two surfaces [2, 7]	Optional
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces [2, 7]	Optional
D6602	Retainer inlay - cast high noble metal, two surfaces [7, 12]	$50.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces [7, 12]	$55.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces [7]	$50.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces [7]	$55.00
D6606	Retainer inlay - cast noble metal, two surfaces [7]	$50.00
D6607	Retainer inlay - cast noble metal, three or more surfaces [7]	$55.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces [2, 7]	Optional
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces [2, 7]	Optional
D6610	Retainer onlay - cast high noble metal, two surfaces [7, 12]	$60.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces [7, 12]	$60.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces [7]	$60.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces [7]	$60.00
D6614	Retainer onlay - cast noble metal, two surfaces [7]	$60.00
D6615	Retainer onlay - cast noble metal, three or more surfaces [7]	$60.00
D6720	Retainer crown - resin with high noble metal [7, 9, 12]	$150.00
D6721	Retainer crown - resin with predominantly base metal [7, 9]	$150.00
D6722	Retainer crown - resin with noble metal [7, 9]	$150.00
D6740	Retainer crown - porcelain/ceramic [2, 7]	Optional
D6750	Retainer crown - porcelain fused to high noble metal [7, 9, 12]	$150.00
D6751	Retainer crown - porcelain fused to predominantly base metal [7, 9]	$150.00
D6752	Retainer crown - porcelain fused to noble metal [7, 9]	$150.00

D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$150.00
D6780	Retainer crown - 3/4 cast high noble metal [7, 12]	$150.00
D6781	Retainer crown - 3/4 cast predominantly base metal [7]	$150.00
D6782	Retainer crown - 3/4 cast noble metal [7]	$150.00
D6784	Retainer crown - 3/4 titanium and titanium alloys	$150.00
D6790	Retainer crown - full cast high noble metal [7, 12]	$150.00
D6791	Retainer crown - full cast predominantly base metal [7]	$150.00
D6792	Retainer crown - full cast noble metal [7]	$150.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker [7]	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$30.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	$10.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$10.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$22.00
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, impacted teeth only	$80.00
D7284	Excisional biopsy of minor salivary glands - *does not include pathology laboratory procedures*	No Cost
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* [3]	$1,600.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* [3]	$1,600.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children* [3]	$1,800.00
D8660	Pre-orthodontic treatment examination to monitor growth and development - *not to be charged with any other consultation procedure(s)* [4]	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) [11]	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 treatment of dental pain - per visit	$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, subsequent to 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 *Limited to 1 per denture during any 12 consecutive months.*

2 *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.*

3 *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.*

4 *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.*

5 *An amalgam is the Benefit.*

6 *A Benefit for permanent teeth only.*

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

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

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

[10] *Includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for three (3) months following installation, if the You continue to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.*

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

[12] *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.*

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

SCHEDULE B

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

Limitations and Exclusions 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 You elect 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 You 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. One 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. One 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 any limitations and exclusions.

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 Dependent 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 13 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 You decline non-covered services within a soft tissue management program, it does not eliminate or alter other covered Benefits.

26. A new removable partial or complete denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if You continue to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered. Immediate dentures and immediate removable partial dentures include after delivery adjustments and tissue conditioning at no additional cost for the first three (3) months after placement.

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 You choose not to start treatment after the diagnosis and consultation have been completed by the Contract Orthodontist, You 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 Your 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.

DELTA DENTAL®

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.

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330
1-866-530-9675
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.

Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call 1-800-422-4234 (TTY: 711).

¿Puede leer este documento? Si no, podemos encontrar a alguien que lo ayude a leerlo. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 1-800-422-4234 (servicio de retransmisión TTY deben llamar al 711). (Spanish)

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)

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)

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 수 있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-800-422-4234 (TTY: 711)번으로 연락하십시오. (Korean)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 1-800-422-4234 (TTY՝ 711): (Armenian)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخواهیم تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 1-800-422-4234 (TTY: 711). (Persian Farsi)

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)

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)

क्या आप इस दस्तावेज़ को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी सहायता करने हेतु किसी की व्यवस्था कर सकते हैं। आप इस दस्तावेज़ को अपनी भाषा में लिखा हुआ भी प्राप्त कर सकते हैं। निशुल्क सहायता के लिए, कृपया यहाँ कॉल करें 1-800-422-4234 (TTY: 711)। (Hindi)

この文書をお読みになれますか？お読みになれない場合には音読ボランティアを手配させていただきます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、1-800-422-4234 (TTY: 711) までお問い合わせください。(Japanese)

ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-800-422-4234 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-800-422-4234 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-800-422-4234 (TTY: 711)។ (Cambodian)

คุณสามารถอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย รับความช่วยเหลือฟรีได้โดยโทรไปที่ 1-800-422-4234 (TTY: 711) (Thai)

If you have any questions or need additional information, call or write:

Toll Free
800-422-4234

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Cerritos, CA 90703