

DeltaCare® USA

Delta Dental Individual & Family™

DeltaCare USA
Individual/Family Dental HMO

CAA54

Combined Policy and Disclosure Form (“Policy”)

Provided 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
888-282-9501 (TTY:711)

deltadentalins.com

POLICY

This DeltaCare USA Individual and Family Dental Plan (“Plan”) is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company (collectively referred to as “Delta Dental”). This Policy is issued in exchange for payment of the first installment of Premium and on the basis of the statements made on Your application. This Policy will remain in force unless otherwise terminated in accordance with its terms, until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where You live.

READ THIS POLICY AND ITS ATTACHMENTS CAREFULLY

Our enrollment materials advise You that this Policy is available upon request, prior to enrollment, by contacting Our Customer Care. You may obtain information about Your plan coverage by calling Our Customer Care at **888-282-9501 (TTY:711)**.

10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

If this Policy was solicited by deceptive advertising or negotiated by deceptive, misleading or untrue statements or if You are not satisfied, You may return this Policy within 10 days after You receive it. Mail or deliver it to Us. Any Premium paid will be refunded. This Policy will then be void from its start.

This Policy is issued and delivered in the state of California and is governed by its laws. If You move and no longer reside in the state of California, please call Customer Care at **888-282-9501**.

This Policy is signed for Delta Dental, as of its Effective Date, by:



Delta Dental of California

Michael G. Hankinson, Esq.

Executive Vice President, Chief Legal and Compliance Officer

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

Information Concerning Benefits Under The DeltaCare USA Plan

THIS MATRIX IS INTENDED TO BE USED TO COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. SCHEDULES A AND B SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF THE PLAN'S BENEFITS, LIMITATIONS AND EXCLUSIONS.

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Professional Services	<p>You may be required to pay a Copayment amount for each procedure as shown in Schedule A, subject to the limitations and exclusions of this Plan. Copayments range by category of service. Examples are as follows:</p> <p>Diagnostic Services No Cost- \$5.00 Preventive Services No Cost- \$85.00 Restorative Services \$15.00 - \$495.00 Endodontic Services \$10.00 - \$725.00 Periodontic Services No Cost- \$650.00 Prosthodontic Services, Removable \$24.00 - \$700.00 Prosthodontic Services, Fixed \$30.00 - \$495.00 Oral and Maxillofacial Surgery No Cost- \$230.00 Orthodontic Services No Cost- \$3220.00 Adjunctive General Services No Cost- \$125.00</p> <p>NOTE: Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to one in a 6-month period.</p>
(D) Outpatient Services	Not Covered
(E) Hospitalization Services	Not Covered

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(F) Emergency Dental Coverage	The Enrollee may receive a maximum Benefit up to \$100.00 per emergency, per Enrollee, for Emergency Dental Services outside of the Delta Dental Service Area.
(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 that is covered under this Plan has a specific Copayment that is shown in *Schedule A* of this Policy.

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INTRODUCTION

This Plan provides dental care through a convenient network of DeltaCare USA Dentists using the DeltaCare USA Individual Network within the Delta Dental Service Area in the state of California. The DeltaCare USA Individual Network is comprised of established dental professionals who are screened to ensure that our standards of quality, access and safety are maintained. When you visit your assigned Contract Dentist, you pay only the applicable Copayment(s) for Benefits covered under this Plan. There are no deductibles, lifetime maximums or claim forms.

Using this Policy

This Policy, including attachments, disclose the terms and conditions of Your coverage and is designed to help You make the most of Your dental plan. It will help You understand how this Plan works and how to obtain dental care. Keep in mind that "You," "Your" and "Yourself" mean the individuals who are covered under this Plan. "We," "Us" and "Our" always refer to Delta Dental or the Administrator.

In addition, please read the "Definitions" section of this Policy as it explains any words with special or technical meanings. Persons with special health care needs should read the "Special Health Care Need" provision. A matrix describing this Plan's major Benefits, limitations and exclusions is located at the beginning of this Policy.

Request Confidential Communications

You may request to receive communications about Your protected health information from Us at an alternate location or by an alternate method. If You would like to submit a new request for confidential communications or revise or cancel an existing one, email it to departmentriskethicsandcompliance@delta.org, mail it to the address below or visit Our website. Your request will be valid until You cancel it or submit a new one.

Contact Us

If You have any questions about Your coverage, please call Customer Care at **888-282-9501** or visit Our website at deltadentalins.com. A representative can help with: answering questions about Your plan, explaining Benefits, locating a Contract Dentist, language assistance services and filing a grievance. You may also write to Us and mail it to:

DeltaCare USA Customer Care

P.O. Box 1803
Alpharetta, GA 30023

Identification Number

An identification ("ID") card containing your ID number is not required when visiting your assigned Contract Dentist, however, you may obtain one on our website at deltadentalins.com.

Definitions

The following are definitions of words that have special or technical meanings under this Policy.

Administrator: Delta Dental Insurance Company or other entity We designate operating as an administrator in the state of California to perform administrative functions described throughout this Policy including, but not limited to, the collection of Premium and eligibility. Also referred to as the "Third Party Administrator" or "TPA."

Authorization: the process by which We determine if a procedure or treatment is a referable Benefit to Enrollees covered under this Plan.

Benefits: covered dental services provided to Enrollees under the terms of this Policy.

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

Contract Dentist: a DeltaCare USA Dentist who provides services in general dentistry and who has agreed to provide Benefits to Enrollees covered under this Plan. Referrals for Specialist Services must be obtained from Your Contract Dentist.

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

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

Copayment: the amounts listed in *Schedule A* attached to this Policy that are charged to You by a DeltaCare USA Dentist for Benefits provided to Enrollees covered under this Plan. Copayments must be paid at the time treatment is received.

Delta Dental Service Area: all geographic areas in the state of California in which We are licensed as a specialized health care service plan to offer this Plan.

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

performed. A dentist also includes a dental partnership, dental professional corporation or dental clinic.

Department of Managed Health Care: a department of the California Health and Human Services Agency who has charge of regulating specialized health care service plans. Also referred to as the "Department" or "DMHC."

Effective Date: the original date this Plan starts. We must receive enrollment materials by the 21st day of the month for coverage to start the first day of the following month. If we receive the enrollment materials after the 21st day of the month, coverage will begin the first day of the second month.

Eligible Dependent: any dependent of the Policyholder who is eligible for Benefits as described in this Policy.

Emergency Dental Condition: dental symptoms and/or pain that are so severe that a reasonable person would believe that, without immediate attention by a Dentist, it could reasonably be expected to 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, or
- death

Emergency Dental Service: 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: a person enrolled to receive Benefits under this Plan. This includes the Primary Enrollee and their Eligible Dependent("Dependent Enrollee").

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

Notice of End of Coverage: the notice sent by Us notifying You that Your coverage has been cancelled.

Notice of Start of Grace Period: the notice sent by Us notifying You that Your plan will be terminated unless the Premium amount due is received no later than the last day of the Grace Period.

Out-of-Network: treatment by a Dentist who has not signed an agreement with Us to provide Benefits to Enrollees covered under this Plan.

Policy: this agreement between Delta Dental and the Policyholder including any attached schedules, appendices, endorsements or riders. This policy constitutes the entire agreement between the parties.

Policyholder: the Primary Enrollee who enrolls for coverage under this Plan.

Policy Term: the one-year period starting on the Effective Date and each annual renewal period during which this Policy remains in effect.

Premium: the amount You pay to Us as stated in the application or renewal notice for coverage under this Plan.

Procedure Code: the Current Dental Terminology ("CDT") number assigned to a Single Procedure by the American Dental Association.

Qualifying Status Change:

- marital status (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);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee moves);
- court order requiring dependent coverage; or
- any other current or future election changes permitted by state or federal law.

Single Procedure: a dental procedure that is assigned a separate Procedure Code.

Special Health Care Need: 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) Your inability to obtain access to Your Contract Dentist facility because of a physical disability; and 2) Your inability to comply with

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

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

Spouse: a person related to or a domestic partner of the Primary Enrollee:

- as defined and as may be required to be treated as a spouse by the laws of the state where this Policy is issued and delivered; or
- as defined and as may be required to be treated as a spouse by the laws of the state where the Primary Enrollee resides.

Teledentistry: the delivery of dental services through telehealth or telecommunications that may include the use of real-time encounter; live video (synchronous) or information stored and forwarded for subsequent review (asynchronous).

Treatment in Progress: any Single Procedure as defined by the CDT Code that has been started while the Enrollee was eligible to receive Benefits and for which multiple appointments are necessary to complete the Single Procedure(s), whether or not the Enrollee continues to be eligible for Benefits under this Plan. Examples include: 1) teeth that have been prepared for crowns, 2) root canals where a working length has been established, 3) full or partial dentures for which an impression has been taken and 4) orthodontics when bands have been placed and tooth movement has begun.

Urgent Dental Services: medically necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

Usual Fee: the fee that an individual Dentist most frequently charges for a given dental service.

We, Us and Our: Delta Dental or the Administrator, as appropriate.

You, Your and Yourself: The individual who is covered under this Plan.

ELIGIBILITY AND ENROLLMENT

Individual adults and their eligible dependents who live or work in the Delta Dental Service Area in California are eligible for coverage under this Plan.

Eligibility Requirements

Policyholders electing to enroll Eligible Dependents must enroll them at the time of initial enrollment, within 90 days of initial enrollment or within 31 days of a Qualifying Status Change.

- Dependents are the Policyholder's Spouse and dependent children from birth to age 26.
- Children include natural children, step-children, foster children, adopted children, children placed for adoption and children of a Spouse.

Over-age dependent children 26 years of age and older may continue to be eligible if:

- 1) they are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition;
- 2) they are chiefly dependent on the Policyholder and/or Spouse for support and maintenance; and

We will notify You at least 90 days prior to the date the dependent child attains the limiting age that their coverage will terminate unless proof of their disability is given to Us within the specified time. Such requests will not be made more than once a year following a 2-year period after this dependent child reaches the limiting age. Eligibility will continue as long as the dependent child relies on You and/or Your Spouse for support and maintenance by reason of a physically or mentally disabling injury, illness or condition.

Dependents in military service are not eligible.

Enrollment Period

Enrollees covered under this Plan must enroll for a minimum of 12 continuous months.

You have the right to terminate coverage under this Plan by sending Us written notice of cancellation. Your coverage and coverage for Your Dependent Enrollee(s) will terminate on the last day of the month that We receive Your request to cancel coverage or the last day of the Policy Term, whichever occurs first. If coverage is voluntarily terminated, You may not re-enroll during the 12 month period immediately following the voluntary termination.

A full refund of Premium is available if a written request for a refund is made within the first 10 days of the Effective Date. After that, all requests for a Premium refund will be pro-rated based upon the number of days remaining in the Policy Term if Premium has been paid in advance. However, a refund may not be available if Benefits were received under Your plan.

PREMIUM PAYMENT RESPONSIBILITIES

You are responsible for making timely Premium payments and for paying a one-time non-refundable application fee when You submit Your application for enrollment under this Plan.

Prepayment Fees/Premiums

The Premium amount, as stated on the application and renewal notice, is to be paid on or before the due date. The due date is the day following the last day of the period for which the preceding Premium was paid. You may pay Your Premium by visiting Our website at deltadentalins.com or by mailing it to:

Delta Dental
P.O. Box 660138
Dallas, TX 75266-0138

Rate Guarantee

Your Premium rate is guaranteed for each Policy Term based upon the new enrollee rates in force at the time of Your enrollment. However, the rate guarantee can be less than a Policy Term if You have an Effective Date mid-year due to a Qualifying Status Change or if You move and/or any current or future election. changes permitted by state or federal law

Unless there is a change in Premium due to Our liability being changed by law or regulation, no change in Premium will become effective within a Policy Term. A change in law or regulation may include a state and/or federal mandated change or a new or increased tax, assessment or fee imposed on the amounts payable to, or by, Us under this Policy or any immediately preceding policy between Delta Dental and You. We would provide written notice to You and this Policy will be modified on the date stated in the notice.

Changing Payment Options

Payment options may be changed at any time. The effective date of any change is the date of the next scheduled payment based on Your new billing period. You can change Your payment option

by visiting Our website at deltadentalins.com or by contacting Customer Care at **888-282-9501**.

RENEWAL OF COVERAGE

No change in Benefits or Premium will be made during a Policy Term. We will send You a renewal notice that includes any proposed changes in Benefits and/or Premiums at least 30 days before Your coverages expires. Your coverage will terminate at the end of the Policy Term unless You renew by paying the applicable Premium on or before the date that Your Policy Term expires.

CANCELLATION, RESCISSION OR NONRENEWAL OF COVERAGE

You may keep this Policy in force by making timely Premium payments. However, We may refuse renewal due to:

- Premiums not paid on or before the last day of the Grace Period. Please refer to "Cancellation of Enrollment Due to Non-Payment of Premiums" provision;
- You are no longer eligible under the terms of this Plan (termination in this case automatically occurs on the last day of the month in which You no longer meet eligibility requirements);
- You are moving out of the state in which this Policy was issued (if You move and no longer reside in the state of California, please contact Customer Care at **888-282-9501**);
- fraud or an intentional misrepresentation of material fact when applying for this coverage or filing a claim for Benefits;
- Your failing to comply with material provisions of this Policy; or
- Our ceasing to renew all Policies issued on this form to residents of the state where You live.

At least 30 days' advance written notice of any nonrenewal action permitted by this provision will be mailed to You at the last address shown in Our records. This notice will include the reason(s) why coverage is being terminated and the date that coverage will end. We will not pay for services received after coverage is terminated. However, We will pay for the completion of Single Procedures started while You were eligible if they are completed within 31 days of the date coverage ended.

If We fail to issue a 30-day advance written notice advising You of Our intent to terminate coverage, Your coverage will remain in effect until 30 days after such notice is given or until the effective date of replacement coverage, whichever occurs first.

In the event of cancellation of enrollment by either Us (except in the case of fraud or deception in the use of services or facilities or knowingly permitting such fraud or deception by another) or You, We will within 30 days return to You the pro rata portion of the money paid to Us which corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due to Us.

CANCELLATION OF ENROLLMENT

Cancellation of Enrollment Due to Non-Payment of Premium

Grace Period

If we do not receive Your Premium payment on or before the due date, Your account will be considered late. We will send You a *Notice of Start of Grace Period* advising that a payment delinquency has triggered a Grace Period beginning the day the *Notice of Start of Grace Period* is dated and that Your coverage will be terminated unless the full Premium amount due is received by Us on or before the last day of the Grace Period. This *Notice of Start of Grace Period* will include vital important information needed to maintain uninterrupted coverage such as: an explanation of the Grace Period, the beginning and end dates of the Grace Period, the dollar amount past due, the date of the last day of paid coverage and a statement explaining the consequences of losing coverage.

Coverage will continue during the Grace Period. Coverage will also continue upon payment of all outstanding Premium amounts received any time before the expiration of the 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.

If, after receiving the *Notice of Start of Grace Period*, Your account remains delinquent after the Grace Period expires, Your coverage will be terminated. We will then send You a *Notice of End of Coverage* within five (5) calendar days after the date Your coverage ends stating the effective date and reason for cancellation of coverage and whom to contact for assistance.

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 You with a *Notice of Cancellation, Rescission or Nonrenewal*. A *Notice of End of Coverage*

will be provided to You for all cancellations after the date coverage has ended, but no later than five (5) calendar days after the date Your coverage has ended that includes the reason for cancellation and whom to contact for assistance.

If coverage 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 Your plan 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, rescission or nonrenewal. Please refer to the following section regarding Your right to submit a grievance.

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"). We will provide You and the DMHC with a disposition or pending status on Your grievance within three (3) calendar days of Our receipt of Your grievance.

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.

OPTION 1 - YOU MAY SUBMIT A GRIEVANCE TO YOUR PLAN.

You may submit online at deltadentalins.com, or call **888-282-9501** or write to:

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

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

Reinstatement of Coverage

If Your coverage is terminated due to nonpayment of Premium and We accept payment of the proper Premiums after termination of this Policy and without requiring a new application, We will reinstate this Policy as though it had never terminated unless We, within 20 business days of receipt of such payment, either: 1) refuse the payment so made; or 2) issue You a new Policy accompanied by written notice stating clearly those respects in which the new Policy differs from this terminated Policy in Benefits, coverage or otherwise.

If You submit a grievance for cancellation, rescission or non-renewal of coverage, including cancellation due to non-payment of Premium, and it is determined that the cancellation is improper, Your coverage may be reinstated retroactive to the date of cancellation, rescission or non-renewal. You are responsible for paying any and all outstanding Premium amounts accrued from the effective date of the cancellation, rescission or non-renewal of coverage before reinstatement. Any outstanding Premium must be paid prior to reinstatement.

OVERVIEW OF DENTAL BENEFITS

This section provides information that will give You a better understanding of how this Plan works and how to make it work best for You.

Benefits, Limitations and Exclusions

This Plan provides Benefits using the DeltaCare USA Individual Network within the Delta Dental Service Area in the state of California during the Policy Term. We pay for Benefits described in the Schedules attached to this Policy.

Dental plans are designed to help with part of Your dental expenses and may not always cover every dental need. The typical plan includes limitations and exclusions, meaning a plan does not cover every aspect of dental care. This can relate to the type of procedures or the number of visits. This Plan provides the Benefits, limitations and exclusions which are detailed in the Schedules that are a part of this Policy and You should make Yourself familiar with them.

Except for Emergency Dental Services, Urgent Dental Services and authorized Specialized Services, Benefits are only available within the Delta Dental Service Area in the state of California.

Copayments and Other Charges

You are required to pay any Copayments listed in *Schedule A* attached to this Policy. Copayments are paid directly to the DeltaCare USA Dentist. Charges for missed or canceled appointments (unless notice is received by the DeltaCare USA Dentist at least 24 hours in advance or an emergency prevented such notice) and charges for after normal visiting hours are also listed in *Schedule A*.

Processing Policies

Claims will be processed in accordance with Our standard processing policies. The processing policies may be revised at the beginning of a Calendar Year to comply with annual CDT Code changes made by the American Dental Association and to reflect changes in generally accepted dental practice standards. We will provide You at least 30 days' advance notice of such changes.

Covered services are performed as deemed appropriate by Your assigned Contract Dentist and are subject to Copayments. If a Contract Dentist believes that You should seek treatment from a specialist, Your Contract Dentist will contact Us for a determination of whether the proposed treatment is a Benefit of Your plan. We will also determine whether the proposed treatment requires treatment

by a specialist. You may contact Customer Care at **888-282-9501** for more information about this Plan's dental care guidelines.

A Benefit appropriately provided through Teledentistry is covered on the same basis and to the same extent that the Benefit is covered through in-person diagnosis, consultation or treatment. The fee for Teledentistry services is considered inclusive in overall patient management and is not a separately payable service.

Non-Covered Services

IMPORTANT: If You opt to receive dental services that are not covered services under this Plan, a DeltaCare USA Dentist may charge You their Usual Fee for those services. Prior to providing a patient with dental services that are not a covered Benefit, the DeltaCare USA Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about dental coverage options, You may call Customer Care at **888-282-9501**. To fully understand Your coverage, you may wish to carefully review this Policy.

HOW TO USE THE DELTACARE USA PLAN/CHOICE OF CONTRACT DENTIST

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW HOW TO OBTAIN DENTAL SERVICES. YOU MUST OBTAIN DENTAL BENEFITS FROM (OR BE REFERRED FOR SPECIALIST SERVICES BY) YOUR ASSIGNED CONTRACT DENTIST.

We provide You with Contract Dentists at convenient locations within the Delta Dental Service Area in the state of California during the Policy Term. Upon enrollment, We will assign You to a Contract Dentist facility. You may request changes to Your assigned Contract Dentist facility by calling Customer Care at **888-282-9501**. A list of Contract Dentists is available at deltadentalins.com. When searching online for a Contract Dentist, select the DeltaCare USA Individual Network to ensure You have the list of Contract Dentists applicable to Your plan. Your change must be requested prior to the 15th of the month to become effective on the first day of the following month.

We will provide You with a written notice of assignment to another Contract Dentist facility near Your home or work if: 1) a requested facility is closed to further enrollment; 2) a chosen Contract Dentist facility withdraws from this Plan; or 3) an assigned facility requests,

for good cause, that You be re-assigned to another Contract Dentist facility.

All Treatment in Progress must be completed before You change to another Contract Dentist facility. For example, this would include: 1) teeth that have been prepared for crowns, 2) root canals where a working length has been established, 3) full or partial dentures for which an impression has been taken and 4) orthodontics when bands have been placed and tooth movement has begun.

All Benefits must be performed at Your assigned Contract Dentist facility. Specialist Services obtained from a Contract Specialist or Contract Orthodontist must be referred Your Contract Dentist. With the exception of Emergency Dental Services, Urgent Dental Services and authorized Specialist Services, this Plan does not pay for services received by Out-of-Network Dentists. All authorized Specialist Services claims will be paid by Us, less any applicable Copayment(s).

If Your assigned Contract Dentist facility terminates participation in this Plan, that Contract Dentist facility will complete all Treatment in Progress, as described above. If, for any reason, Your Contract Dentist is unable to complete treatment, We will make reasonable and appropriate provisions for the completion of such treatment by another Contract Dentist. We will give You reasonable advance written notice if You will be materially or adversely affected by the termination, breach of contract or inability of a Contract Dentist to perform services.

Continuity of Care

If You are a current Enrollee or newly covered Enrollee, You may have the right to obtain completion of care based on Our contract with Your terminated Contract Dentist for certain specified dental conditions. If You are a new Enrollee, You may have the right to completion of care under the Contract with your Out-of-Network Dentist for certain specified dental conditions. You must make a specific request for this completion of care Benefit. To make a request, contact Customer Care at **888-282-9501**. You may also contact Us to request a copy of Our *Continuity of Care Policy*. We are not required to continue care with the Dentist if You are not eligible under this Plan or if We cannot reach agreement with the Out-of-Network Dentist or the terminated Contract Dentist on the terms regarding Your care in accordance with California law.

Specialist Services

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

We will pay claims for all authorized Specialist Services, less any applicable Copayment(s). If you require Specialist Services and a Contract Specialist or Contract Orthodontist is not within 35 miles of Your home address to provide these services, Your assigned Contract Dentist must obtain prior Authorization from Us to refer You to an Out-of-Network specialist or Out-of-Network orthodontist. Specialist Services performed by an Out-of-Network specialist or Out-of-Network orthodontist that are not authorized by Us will not be covered by this Plan. If the services of a Contract Orthodontist are needed, please refer to the Schedules attached to this Policy to determine Benefits available to you under this Plan.

A Contract Dentist may provide Specialist Services either personally or through associated Dentists, technicians or hygienists who may lawfully perform these services. If You are assigned to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

Emergency Dental Services

Emergency Dental Services are palliative relief, controlling of dental pain and/or stabilizing the Enrollee's condition. The Enrollee's assigned Contract Dentist facility maintains a 24-hour emergency dental services system, 7 days a week. If the Enrollee is experiencing an Emergency Dental Condition, the Enrollee can call **911** (where available) or obtain Emergency Dental Services from any Dentist without a referral.

After Emergency Dental Services are received, further non-emergency treatment is usually needed. Non-emergency treatment must be obtained at Your assigned Contract Dentist facility. You are responsible for any Copayment(s) for Emergency Dental Services received. You are also financially responsible for non-covered services. Non-covered services are not paid by this Plan.

You are responsible for any Copayment(s) for Emergency Dental Services received. You are also financially responsible for non-covered services. Non-covered services are not paid by this Plan.

Urgent Dental Services

Inside the Delta Dental Service Area

An Urgent Dental Service requires prompt dental attention but it is not an Emergency Dental Condition. If You believe that You need Urgent Dental Services, You can call Your assigned Contract Dentist during normal business hours or after hours.

Outside the Delta Dental Service Area

If You need Urgent Dental Services due to an unforeseen dental condition or injury, this Plan covers 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 an Out-of-Network Dentist while temporarily outside the Delta Dental Service Area.
- You believed that Your health would seriously deteriorate if You delayed treatment until You returned to the Delta Dental Service Area.

You do not need prior Authorization from Us to receive Urgent Dental Services outside the Delta Dental Service Area. Any Urgent Dental Services You receive from an Out-of-Network Dentist outside the Delta Dental Service Area are covered by this Plan if the Benefits would have been covered if You had received them from a Contract Dentist.

This Plan does not cover follow-up care from an Out-of-Network Dentist after You no longer need Urgent Dental Services. To obtain follow-up care from a Dentist, You may call Your assigned Contract Dentist. You are responsible for any Copayment(s) for Urgent Dental Services received.

Timely Access to Care

DeltaCare USA Dentists have agreed waiting times to Enrollees for appointments for care which will never be greater than the following timeframes:

- for emergency care, 24 hours a day, 7 day days a week;
- for any urgent care, 72 hours for appointments consistent with the Enrollee's individual needs;
- for any non-urgent care, 36 business days; and
- for any preventive services, 40 business days.

During non-business hours, You have access to Your Contract Dentist's answering machine, answering service, cell phone or pager for guidance on what to do and who to contact for Urgent Dental

Services or if You are experiencing an Emergency Dental Condition including while outside of the Delta Dental Service area.

A Customer Care representative will answer Your call within 10 minutes during normal business hours.

Language Interpretation Services

We offer qualified interpretation services to limited-English proficient Enrollees, at no cost to the Enrollee, at all points of contact in any modern language, including when an Enrollee is accompanied by a family member or friend who can provide language interpretation services.

If You need language interpretation services, materials translated into Your preferred language or into an alternate format, please call Customer Care at **888-282-9501(TTY 711)**. You may also visit Our [online dentist directory](#) which includes self-reported languages by DeltaCare USA Dentists

Claims for Reimbursement

Claims for covered Emergency Dental Services, Urgent Dental Services and authorized Specialist Services should be sent to Us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if You can show that it was not reasonably possible to submit the claim within that time. All dental claims submissions must be received within one (1) year of the treatment date. The address for dental claims submission is Delta Dental - Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Dentist Compensation

A Contract Dentist is compensated by Us through monthly capitation (an amount based on the number of enrollees assigned to the Contract Dentist facility) and by Enrollees through required Copayments for treatment received. A Contract Specialist and a Contract Orthodontist are compensated by Us through an agreed upon amount for each covered procedure, less the applicable Copayment(s) paid by You. In no event do We pay a DeltaCare USA Dentist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

In the event that We fail to pay Your DeltaCare USA Dentist, You will not be liable to that Dentist for any sums owed by Us. By statute, the DeltaCare USA Dentist agreement contains a provision prohibiting them from charging You for any sums owed by Us.

Except for Emergency Dental Services, Urgent Dental Services and authorized Specialist Services, 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 Out-of-Network Dentist for the cost of services received.

You may call Customer Care at **888-282-9501** to obtain further information about Dentist compensation.

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 imminent and serious health threat to Your health including, but not limited to, the potential loss of life, limb or other major bodily function or lack of timeliness that would be detrimental to Your ability to regain maximum function, the second opinion will be expedited (Authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion Authorizations, call Customer Care at **888-282-9501** or write to Us.

Second opinions will be provided at another Contract Dentist facility, unless otherwise authorized by Us. We will authorize a second opinion by an Out-of-Network Dentist if an appropriately qualified Contract Dentist is not available. We will only pay for a second opinion that 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 Us or with the DMHC. Refer to the "Enrollee Claims Complaint Procedure" section for information regarding complaint procedures.

Special Health Care Need

If you believe You have a Special Health Care Need, You should contact Customer Care at **888-282-9501 TTY:711**. 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 dental facilities provide Us with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding dental facility accessibility, contact Customer Care at **888-282-9501** or visit Our website at deltadentalins.com.

ENROLLEE CLAIMS COMPLAINT PROCEDURE

We, or our Administrator, will notify You if any dental services or claims are denied, in whole or in part, stating the specific reason(s) for the denial. If You have a complaint regarding eligibility, the denial of dental services or claims, Our policies, procedures or operations or the quality of dental services performed by a DeltaCare USA Dentist, You may call Customer Care at **888-282-9501 TTY:711**, complete and submit a **DeltaCare USA Enrollee Grievance Form** online or mail Your complaint to:

Delta Dental USA Quality Management Department
P.O. Box 997330
Sacramento, CA 95899

Written communication must include: 1) the patient's name, 2) the Enrollee's name, address, telephone number and ID number and 3) the Contract Dentist's name and facility location.

"Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by the Enrollee or the Enrollee's representative. Where this Plan is unable to distinguish between a grievance and an inquiry, it will be considered a grievance.

"Complaint" is the same as "grievance".

"Complainant" is the same as "grievant" and means the person who filed the grievance including the Enrollee, a representative designated by the Enrollee or other individual with authority to act on behalf of the Enrollee.

Within five (5) calendar days of Our receipt of any complaint, a quality management coordinator will forward to You a written acknowledgment of the complaint which will include the date of Our receipt and plan contact information. Certain complaints may

require that You be referred to a Dentist for clinical evaluation of the dental services provided. We will forward to You a determination, in writing, within 30 calendar days of Our receipt of Your grievance.

Our grievance system ensures all plan Enrollees have access to and can fully participate in Our grievance process by providing assistance to those with limited English proficiency or with visual or other communicative impairments. Such assistance includes, but is not limited to, translations of grievance procedures, forms and plan responses to grievances as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. If You are in need of these services and/or have questions about Our grievance process, please contact Customer Care at **888-282-9501 TTY: 711** and/or visit our website at deltadentalins.com to complete and submit a **DeltaCare USA Enrollee Grievance Form**.

Our grievance system allows Enrollees to file grievances for at least 180 calendar days following any incident or action that is the subject of the Enrollee's dissatisfaction. You will not be discriminated against in any way by Us for filing a grievance.

You may file a complaint with the DMHC after completing Our grievance process or if You have been involved in Our grievance process for more than 30 days. You may seek assistance or file a grievance immediately with the DMHC in cases involving an imminent and serious threat to Your health including, but not limited to, severe pain, potential loss of life, limb or major bodily function. In such case, We will provide You with written statement on the disposition or pending status of Your grievance no later than three (3) days from the date of Our receipt of Your grievance. You may file a complaint with the DMHC immediately if You are experiencing an Emergency Dental Condition.

Complaints Involving an Adverse 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 this Policy, 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 available upon request. If You believe that the decision was denied on the grounds that it was not medically necessary, You may contact the DMHC to determine if the decision is eligible for an independent medical review. You will not be discriminated against by Us in any way for filing a grievance.

California law requires that We provide You with the following information:

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 **888-282-9501** 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, 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 or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

GENERAL PROVISIONS

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 communications from enrollees. You may submit any suggestions regarding Our public policy in writing to:

DeltaCare USA Customer Care
P.O. Box 997330
Sacramento, CA 95899-7330

Entire Policy; Changes

This Policy and any attached schedules, appendices, endorsements or riders constitute the entire agreement governing this Plan. No amendment is valid unless approved by an executive officer of Delta Dental and attached to this Policy. No agent or broker has authority to amend this Plan or waive any of its provisions.

Severability

If any part of this Policy, or an amendment of it, is found by a court or other authority to be illegal, void or not enforceable, all other portions of this Policy will remain in full force and effect.

Incontestability

We shall not rescind or limit any provisions of this Policy once You are covered under this Plan unless We can demonstrate that You performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of this Policy. If We can demonstrate the aforementioned, We will send a notice to You at least 30 days prior to the effective date of rescinding Your Plan explaining the reason(s) for the intended rescission and advising You of Your right to appeal this decision to the director of the DMHC.

After 24 months following the issuance of this Policy, We will not rescind, cancel or limit any provisions nor raise Premiums for any reason due to any omissions, misrepresentations or inaccuracies in the application form, whether willful or not.

Misstatements on Application; Effects

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under this Policy, all statements made by You will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Policy unless it is contained in a written application. If any misstatement would materially affect the rates, We reserve the right to adjust the Premium to reflect Your actual circumstances at time of application or to terminate Your Policy.

Clinical Examination

Before approving a claim, We will be entitled to receive, to such extent as may be lawful, from any attending or examining Dentist or from hospitals in which a Dentist's care is provided, such information and records relating to the attendance to or examination of, or treatment provided to You as may be required to administer the claim. Examination may be required by a dental consultant retained by Us in or near Your community or residence. We will, in every case, hold such information and records confidential.

Legal Actions

No action at law or in equity will be brought to recover on this Policy prior to expiration of 60 days after proof of loss has been filed

in accordance with requirements of this Policy. No action can be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by this Policy.

Conformity with Applicable Laws

All legal questions about this Policy will be governed by the state of California where this Policy was entered into and is to be performed. Any part of this Policy that conflicts with the laws of California, specifically Chapter 2.2 of Division 2 of the California Health and Safety Code and Chapter 1 of Division 1, of Title 28 of the California Code of Regulations, or federal law is hereby amended to conform to the minimum requirements of such laws. Any provision required to be in this Policy by either of the above will bind Us whether or not provided in this Policy.

Third Party Administrator ("TPA")

We may use the services of a TPA, duly registered under applicable state law, to provide services under this Policy. Any TPA providing such services or receiving such information will enter into a separate business associate agreement with Us providing that the TPA meets HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

Organ and Tissue Donation

Donating organ 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 to Your physician. Organ donation begins at the hospital when a person is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

Impossibility of Performance

Neither party (Policyholder or Delta Dental) will be liable to the other or be deemed to be in breach of this Policy for any failure or delay in performance arising out of causes beyond its reasonable control. Such causes are strictly limited to include acts of God or of a public enemy, explosion, fires or unusually severe weather. Dates and times of performance will be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay.

Non-Discrimination

We comply with applicable federal civil rights laws and does 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)
- 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, call Our Customer Care at **800-422-4234**
TTY: 711.

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 Care representative or by mail.

DeltaCare USA
P.O. Box 1803
Alpharetta, GA 30023
Phone Number: **800-422-4234 (TTY: 711)**
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 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
1-800-537-7697 (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 needed and deemed necessary by Your assigned Contract Dentist subject to the limitations and exclusions of the DeltaCare USA Plan ("Plan"). Please refer to *Schedule B, Limitations and Exclusions of Benefits* (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 this Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2025 Procedure Codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT Procedure Codes or definitions. Such updated Procedure Codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>YOU PAY</u>
D0100-D0999	I. DIAGNOSTIC	
	<i>- Procedure Codes below with age restrictions are subject to exceptions based on medical necessity.</i>	
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 - <i>limited to 1 of (D0210 or D0330) per 24 months, Either one (1) D0210 or one (1) D0330 permitted</i>	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
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings two radiographic images - <i>limited to 1 series every 6 months</i>	No Cost
D0273	Bitewings three radiographic images - <i>limited to 1 series every 6 months</i>	No Cost
D0274	Bitewings - four radiographic images - <i>limited to 1 series every 6 months</i>	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image - <i>limited to 1 of (D0210 or D0330) per 24 months, Either one (1) D0210 or one (1) D0330 permitted</i>	No Cost
D0396	3D printing of a 3D dental surface scan	No Cost
D0419	Assessment of salivary flow by measurement - <i>1 every 12 months</i>	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 - <i>available only when performed in conjunction with a covered biopsy</i>	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report - <i>available only when performed in conjunction with a covered biopsy</i>	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 - <i>available only when performed in conjunction with a covered biopsy</i>	No Cost

D0601	Caries risk assessment and documentation, with a finding of low risk - <i>1 every 12 months</i>	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 12 months</i>	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 12 months</i>	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 - <i>includes office visit, per visit (in addition to other services)</i>	\$5.00

D1000-D1999 II. PREVENTIVE

- Procedure Codes below with age restrictions are subject to exceptions based on medical necessity.

D1110	Prophylaxis <i>cleaning</i> - adult - <i>1 per 6 month period</i>	\$5.00
D1120	Prophylaxis <i>cleaning</i> - child - <i>1 per 6 month period</i>	\$5.00
D1206	Topical application of fluoride varnish - <i>child to age 19; 1 per 6 month period</i>	\$5.00
D1208	Topical application of fluoride - excluding varnish ..	\$5.00
D1310	Nutritional counseling for control of dental disease	No Cost
D1320	Tobacco counseling for the control and prevention of oral disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars through age 15</i>	\$22.00

D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - <i>limited to permanent molars through age 15</i>	\$22.00
D1353	Sealant repair - per tooth	\$22.00
D1354	Application of caries arresting medicament - per tooth	\$20.00
D1510	Space maintainer - fixed - unilateral - per quadrant	\$85.00
D1516	Space maintainer - fixed - bilateral, maxillary	\$85.00
D1517	Space maintainer - fixed - bilateral, mandibular	\$85.00
D1520	Space maintainer - removable - unilateral - per quadrant	\$85.00
D1526	Space maintainer - removable - bilateral, maxillary .	\$85.00
D1527	Space maintainer - removable - bilateral, mandibular	\$85.00
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	\$85.00

D2000-D2999 III. RESTORATIVE

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

- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

D2140	Amalgam - one surface, primary or permanent	\$15.00
D2150	Amalgam - two surfaces, primary or permanent	\$20.00
D2160	Amalgam - three surfaces, primary or permanent ..	\$25.00
D2161	Amalgam - four or more surfaces, primary or permanent	\$30.00
D2330	Resin-based composite - one surface, anterior	\$35.00
D2331	Resin-based composite - two surfaces, anterior	\$40.00

D2332	Resin-based composite - three surfaces, anterior ...	\$45.00
D2335	Resin-based composite - four or more surfaces (anterior)	\$60.00
D2390	Resin-based composite crown, anterior	\$60.00
D2391	Resin-based composite - one surface, posterior	\$35.00
D2392	Resin-based composite - two surfaces, posterior ...	\$40.00
D2393	Resin-based composite - three surfaces, posterior .	\$60.00
D2394	Resin-based composite - four or more surfaces, posterior	\$60.00
D2510	Inlay - metallic - one surface ¹	\$260.00
D2520	Inlay - metallic - two surfaces ¹	\$270.00
D2530	Inlay - metallic - three or more surfaces ¹	\$280.00
D2542	Onlay - metallic - two surfaces ¹	\$270.00
D2543	Onlay - metallic - three surfaces ¹	\$290.00
D2544	Onlay - metallic - four or more surfaces	\$300.00
D2610	Inlay - porcelain/ceramic - one surface ^{2, 5}	\$350.00
D2620	Inlay - porcelain/ceramic - two surfaces ^{2, 5}	\$385.00
D2630	Inlay - porcelain/ceramic - three or more surfaces ^{2,} ⁵	\$405.00
D2642	Onlay - porcelain/ceramic - two surfaces ^{2, 5}	\$415.00
D2643	Onlay - porcelain/ceramic - three surfaces ^{2, 5}	\$415.00
D2644	Onlay - porcelain/ceramic - four or more surfaces ^{2,} ⁵	\$425.00
D2650	Inlay - resin-based composite - one surface ⁵	\$250.00
D2651	Inlay - resin-based composite - two surfaces ⁵	\$275.00
D2652	Inlay - resin-based composite - three or more surfaces ⁵	\$310.00
D2662	Onlay - resin-based composite - two surfaces ⁵	\$305.00
D2663	Onlay - resin-based composite - three surfaces ⁵	\$330.00
D2664	Onlay - resin-based composite - four or more surfaces ⁵	\$375.00
D2710	Crown - resin-based composite (indirect) ⁵	\$125.00
D2712	Crown - 3/4 resin-based composite (indirect) ⁵	\$125.00
D2720	Crown - resin with high noble metal ⁵	\$425.00
D2721	Crown - resin with predominantly base metal ⁵	\$325.00
D2722	Crown - resin with noble metal ⁵	\$425.00

D2740	Crown - porcelain/ceramic ^{2, 5}	\$375.00
D2750	Crown - porcelain fused to high noble metal ^{2, 3, 5}	\$300.00
D2751	Crown - porcelain fused to predominantly base metal ^{3, 5}	\$250.00
D2752	Crown - porcelain fused to noble metal ^{3, 5}	\$300.00
D2753	Crown - porcelain fused to titanium and titanium alloys ^{2, 3, 5}	\$300.00
D2780	Crown - 3/4 cast high noble metal	\$425.00
D2781	Crown - 3/4 cast predominantly base metal	\$325.00
D2782	Crown - 3/4 cast noble metal	\$425.00
D2783	Crown - 3/4 porcelain/ceramic ^{2, 5}	\$495.00
D2790	Crown - full cast high noble metal	\$425.00
D2791	Crown - full cast predominantly base metal	\$325.00
D2792	Crown - full cast noble metal	\$425.00
D2794	Crown - titanium and titanium alloys	\$495.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$15.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$15.00
D2920	Re-cement or re-bond crown	\$15.00
D2921	Reattachment of tooth fragment, incisal edge or cusp (<i>anterior</i>)	\$115.00
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	\$55.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - <i>anterior</i>	\$95.00
D2930	Prefabricated stainless steel crown - primary tooth	\$55.00
D2931	Prefabricated stainless steel crown - permanent tooth	\$55.00
D2932	Prefabricated resin crown - <i>anterior primary tooth</i> .	\$95.00
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i>	\$95.00
D2940	Placement of interim direct restoration	\$10.00
D2949	Restorative foundation for an indirect restoration ..	\$85.00
D2950	Core buildup, including any pins when required	\$85.00
D2951	Pin retention - per tooth, in addition to restoration .	\$30.00
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i> ¹	\$85.00

D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> ¹	\$50.00
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	\$75.00
D2955	Post removal	\$40.00
D2956	Removal of an indirect restoration on a natural tooth	No Cost
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	\$45.00
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework.	\$65.00
D2976	Band stabilization - per tooth - <i>limited to 1 per tooth per lifetime</i>	\$25.00
D2980	Crown repair necessitated by restorative material failure	\$50.00
D2981	Inlay repair necessitated by restorative material failure	\$50.00
D2982	Onlay repair necessitated by restorative material failure	\$50.00
D2983	Veneer repair necessitated by restorative material failure	\$50.00
D2989	Excavation of a tooth resulting in the determination of non-restorability	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to 1 per 24 months</i>	\$22.00

D3000-D3999 IV. ENDODONTICS

- *With the exception of pulp caps, pulpotomies, pulpal debridements, and pulpal therapies with resorbable fillings, all endodontic procedures listed below are Benefits for permanent teeth only.*

D3110	Pulp cap - direct (excluding final restoration)	\$10.00
D3120	Pulp cap - indirect (excluding final restoration)	\$10.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$45.00
D3221	Pulpal debridement, primary and permanent teeth	\$45.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	\$45.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$45.00

D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$45.00
D3310	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration)	\$230.00
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	\$300.00
D3330	Endodontic therapy, molar tooth (excluding final restoration)	\$340.00
D3331	Treatment of root canal obstruction; non-surgical access	\$230.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$240.00
D3346	Retreatment of previous root canal therapy - anterior	\$500.00
D3347	Retreatment of previous root canal therapy - premolar	\$600.00
D3348	Retreatment of previous root canal therapy - molar	\$725.00
D3410	Apicoectomy - anterior	\$470.00
D3421	Apicoectomy - premolar (first root)	\$535.00
D3425	Apicoectomy - molar (first root)	\$580.00
D3426	Apicoectomy (each additional root)	\$115.00
D3430	Retrograde filling - per root	\$65.00
D3450	Root amputation - per root	\$315.00
D3471	Surgical repair of root resorption - anterior	\$470.00
D3472	Surgical repair of root resorption - premolar	\$470.00
D3473	Surgical repair of root resorption - molar	\$470.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	\$470.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	\$470.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar ...	\$470.00
D3920	Hemisection (including any root removal), not including root canal therapy	\$95.00
D3921	Decoronation or submergence of an erupted tooth	\$40.00

D4000-D4999

V. PERIODONTICS

- Includes postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$260.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$150.00
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	\$350.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$280.00
D4249	Clinical crown lengthening - hard tissue	\$280.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$650.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$520.00
D4270	Pedicle soft tissue graft procedure	\$290.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	\$95.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	\$300.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	\$300.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$40.00

D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	\$20.00
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i>	\$50.00
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i>	\$40.00
D4921	Gingival irrigation with a medicinal agent - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment 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 the first three months after placement. You must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

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

D5110	Complete denture - maxillary	\$495.00
D5120	Complete denture - mandibular	\$495.00
D5130	Immediate denture - maxillary	\$550.00
D5140	Immediate denture - mandibular	\$550.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$400.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$400.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$565.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$565.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$400.00

D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$400.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$565.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$565.00
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 ...	\$700.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	\$700.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$400.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$400.00
D5410	Adjust complete denture - maxillary	\$24.00
D5411	Adjust complete denture - mandibular	\$24.00
D5421	Adjust partial denture - maxillary	\$24.00
D5422	Adjust partial denture - mandibular	\$24.00
D5511	Repair broken complete denture base, mandibular .	\$55.00
D5512	Repair broken complete denture base, maxillary	\$55.00
D5520	Replace missing or broken teeth - complete denture - per tooth	\$40.00
D5611	Repair resin partial denture base, mandibular	\$60.00
D5612	Repair resin partial denture base, maxillary	\$60.00
D5621	Repair cast partial framework, mandibular	\$60.00
D5622	Repair cast partial framework, maxillary	\$60.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	\$75.00
D5640	Replace missing or broken teeth - partial denture - per tooth	\$45.00
D5650	Add tooth to existing partial denture - per tooth	\$60.00
D5660	Add clasp to existing partial denture - per tooth	\$75.00
D5710	Rebase complete maxillary denture	\$180.00
D5711	Rebase complete mandibular denture	\$180.00

D5720	Rebase maxillary partial denture	\$180.00
D5721	Rebase mandibular partial denture	\$180.00
D5725	Rebase hybrid prosthesis	\$180.00
D5730	Reline complete maxillary denture (chairside)	\$75.00
D5731	Reline complete mandibular denture (chairside)	\$75.00
D5740	Reline maxillary partial denture (chairside)	\$75.00
D5741	Reline mandibular partial denture (chairside)	\$75.00
D5750	Reline complete maxillary denture (laboratory)	\$150.00
D5751	Reline complete mandibular denture (laboratory) ..	\$150.00
D5760	Reline maxillary partial denture (laboratory)	\$150.00
D5761	Reline mandibular partial denture (laboratory)	\$150.00
D5765	Soft liner for complete or partial removable denture - indirect	\$150.00
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - <i>limited to 1 in any 12 consecutive months</i>	\$175.00
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - <i>limited to 1 in any 12 consecutive months</i>	\$175.00
D5850	Tissue conditioning, maxillary	\$40.00
D5851	Tissue conditioning, mandibular	\$40.00

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])

- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	\$425.00
D6211	Pontic - cast predominantly base metal	\$325.00
D6212	Pontic - cast noble metal	\$425.00
D6240	Pontic - porcelain fused to high noble metal ^{2,5}	\$425.00
D6241	Pontic - porcelain fused to predominantly base metal ⁵	\$325.00
D6242	Pontic - porcelain fused to noble metal ⁵	\$425.00
D6243	Pontic - porcelain fused to titanium and titanium alloys ⁵	\$425.00

D6245	Pontic - porcelain/ceramic ^{2, 5}	\$495.00
D6250	Pontic - resin with high noble metal ⁵	\$425.00
D6251	Pontic - resin with predominantly base metal ⁵	\$325.00
D6252	Pontic - resin with noble metal ⁵	\$425.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces ^{2, 5} .	\$385.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces ^{2, 5}	\$405.00
D6602	Retainer inlay - cast high noble metal, two surfaces	\$370.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	\$380.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	\$270.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	\$280.00
D6606	Retainer inlay - cast noble metal, two surfaces	\$370.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	\$380.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces ^{2, 5}	\$395.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces ^{2, 5}	\$415.00
D6610	Retainer onlay - cast high noble metal, two surfaces	\$370.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	\$390.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	\$270.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	\$290.00
D6614	Retainer onlay - cast noble metal, two surfaces	\$370.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	\$390.00
D6720	Retainer crown - resin with high noble metal ⁵	\$425.00
D6721	Retainer crown - resin with predominantly base metal ⁵	\$325.00
D6722	Retainer crown - resin with noble metal ⁵	\$425.00
D6740	Retainer crown - porcelain/ceramic ^{2, 5}	\$495.00
D6750	Retainer crown - porcelain fused to high noble metal ^{2, 3, 5}	\$425.00

D6751	Retainer crown - porcelain fused to predominantly base metal ^{3, 5}	\$325.00
D6752	Retainer crown - porcelain fused to noble metal ^{3, 5}	\$425.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys ^{2, 3, 5}	\$425.00
D6780	Retainer crown - 3/4 cast high noble metal	\$425.00
D6781	Retainer crown - 3/4 cast predominantly base metal	\$325.00
D6782	Retainer crown - 3/4 cast noble metal	\$425.00
D6783	Retainer crown - 3/4 porcelain/ceramic ^{2, 5}	\$495.00
D6784	Retainer crown - 3/4 titanium and titanium alloys ..	\$425.00
D6790	Retainer crown - full cast high noble metal	\$425.00
D6791	Retainer crown - full cast predominantly base metal	\$325.00
D6792	Retainer crown - full cast noble metal	\$425.00
D6930	Re-cement or re-bond fixed partial denture	\$30.00
D6940	Stress breaker	\$50.00
D6980	Fixed partial denture repair necessitated by restorative material failure	\$75.00

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	\$30.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$40.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$70.00
D7220	Removal of impacted tooth - soft tissue	\$100.00
D7230	Removal of impacted tooth - partially bony	\$190.00
D7240	Removal of impacted tooth - completely bony	\$210.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$230.00
D7250	Removal of residual tooth roots (cutting procedure)	\$75.00
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	\$230.00
D7252	Partial extraction for immediate implant placement - <i>Once in a lifetime</i>	\$70.00

D8030	Limited orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i>	\$1,400.00
D8040	Limited orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i>	\$1,600.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i>	\$2,600.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i>	\$2,600.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i>	\$2,800.00
D8091	Comprehensive orthodontic treatment with orthognathic surgery - <i>adults, including covered dependent adult children</i>	\$3,220.00
D8660	Pre-orthodontic treatment examination to monitor growth and development ⁴	No Cost
D8670	Periodic orthodontic treatment visit	No Cost
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of <i>removable</i> retainers)	\$250.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - <i>includes treatment planning session</i>	\$200.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative treatment of dental pain - per visit	\$35.00
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	\$70.00
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	\$40.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	No Cost
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
D9951	Occlusal adjustment, limited	\$40.00
D9952	Occlusal adjustment, complete	\$90.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - <i>limited to one bleaching tray and gel for two weeks of self-treatment</i>	\$125.00
D9986	Missed appointment - <i>without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00</i>	\$10.00
D9987	Canceled appointment - <i>without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00</i>	\$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

Teledentistry services provided by a Dentist other than Your Contract Dentist are considered Out-of-Network and may result in an out-of-pocket cost to You, unless coverage is required under other law.

If services for a listed procedure are performed by Your assigned Contract Dentist, You pay the specified Copayment. Listed procedures which require a Contract Specialist or Contract Orthodontist to provide Specialist Services and are referred by Your assigned Contract Dentist must be authorized by Us. You pay the Copayment(s) specified for such services.

FOOTNOTES

- 1 Base metal is the Benefit. If an inlay, onlay or indirectly fabricated post and core is made of high noble metal or noble metal, an additional fee up to \$100.00 per tooth will be charged for the upgrade.*
- 2 Name brand, laboratory processed or in-office processed crowns/ pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed \$325.00 in addition to the listed Copayment. Refer to Limitation of Benefits #4 in Schedule B for additional information.*
- 3 For a covered porcelain-fused-to-metal crown, a porcelain margin is considered a material upgrade with a maximum additional charge to You of \$75.00 per unit.*
- 4 In the event orthodontic treatment is not required or is declined by You, a fee of \$85.00 will apply. You are also responsible for any incurred orthodontic diagnostic record fees.*
- 5 Porcelain/ceramic crown, pontic and fixed bridge retainer on molars are considered a material upgrade with a maximum additional charge to You of \$150.00 per unit.*

SCHEDULE B

Limitations and Exclusions of Benefits

Limitations below with age restrictions are subject to exceptions based on medical necessity.

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*. ("Schedule A").
2. Fillings (amalgams and composites) are Benefits for the removal of decay, for minor repairs of tooth structure or to replace a lost or failing restoration.
3. The placement of a crown, inlay or onlay is a Benefit when there is insufficient tooth structure to support a filling.
4. Contract Dentists may offer services that utilize brand or trade names at an additional fee. You must be offered the Plan Benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If You choose the alternative of a material upgrade (name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec), the Contract Dentist may charge an additional fee not to exceed \$325.00 in addition to the listed Copayment. Contact Customer Care at 888-282-9501 if You have questions regarding the additional fee or name brand services.
5. 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.

6. Coverage for the placement of a fixed partial denture (bridge) requires that:
 - a. No cantilevered posterior pontic (prosthetic tooth) be included;
and
 - 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; **or**
 - Each abutment tooth to be crowned meets Limitation #3.
7. Benefits for retained primary teeth are limited to services applicable to a primary tooth.
8. Excision of the frenum is a Benefit only when it causes limited mobility of the tongue, a large diastema between teeth or it interferes with a prosthetic appliance.
9. Benefits provided by a pediatric Dentist are limited to Dependent Enrollees through age 13 less applicable Copayments. This Plan will consider exceptions on an individual basis if a child has a physical or mental impairment, limitation or condition which substantially interferes with that child's ability to have Benefits provided by a Contract Dentist.
10. Benefits for a soft tissue management program are limited to those parts which are listed covered services listed in *Schedule A*. If You decline non-covered services (including irrigation) within a soft tissue management program, it does not eliminate or alter other covered Benefits.
11. 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, You are responsible for the cost at the Contract Orthodontist's Usual Fee.
12. 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.

13. The Copayment is payable to the Contract Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, You change to another Contract Orthodontist to continue orthodontic treatment, You:
 - a. will not be entitled to a refund of any amounts previously paid;
and
 - b. will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.
14. The cost to You receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's Usual Fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. You make payment directly to the Contract Orthodontist as arranged.
15. Teledentistry services provided by a Dentist other than Your Contract Dentist are considered Out-of-Network and may result in an out-of-pocket cost to You.
16. X-ray Limitations:
 - When the frequencies for the comprehensive radiographic images (D0210) and panoramic radiographic images (D0330) differ, the least restrictive frequency will apply.
 - Panoramic images are not considered part of a comprehensive intraoral series.
 - Bitewing x-rays of any type are included in the fee of a comprehensive series when taken within 6 months of the comprehensive images.
 - Bitewing x-rays are limited to two images for under age 10.
 - Image capture procedures are not separately billable services.

Exclusions of Benefits

Exclusions below with age restrictions are subject to exceptions based on medical necessity.

1. Any procedure that is not specifically listed under *Schedule A*.
2. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
3. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges) and orthodontic appliances.
4. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
5. Dental expenses incurred in connection with any dental procedure started before Your eligibility with the DeltaCare USA Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics.
6. Prescription and over-the-counter drugs.
7. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.
8. Dental services received from any dental facility other than the assigned Contract Dentist, or a preauthorized Contract Specialist (oral surgeon, endodontist, periodontist, pediatric Dentist or Contract Orthodontist), except for Emergency Dental Services and Urgent Dental Services as described in the Policy.
9. Consultations or other diagnostic services for non-covered Benefits.
10. Duplication of x-rays.
11. Implant supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
12. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.

13. Services solely for cosmetic purposes, with the exception of procedure D9975 (external bleaching for home application, per arch).
14. Procedures, appliances or restorations if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), with the exception of Procedure Codes D9951 and D9952, as shown on Schedule A.
15. 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 reconstruction under the DeltaCare USA Plan. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusion does not affect any other Benefits.
16. 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.
17. 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.
18. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.
19. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services;
20. Accidental injury. Accidental injury is defined as damage to the hard and soft tissue of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of Benefits.
21. Myofunctional and parafunctional appliances and/or therapies.
22. Composite or ceramic brackets, lingual adaptation of orthodontic bands.

23. Pre-, mid- and post-treatment records for orthodontia including cephalometric x-rays, tracings, photographs and study models.
24. Changes in orthodontic treatment necessitated by accident of any kind.
25. Orthodontic treatment must be provided by a licensed dentist.
26. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.
27. Services or supplies for sleep apnea.



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HIPAA Notice of Privacy Practices

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our privacy practices reflect applicable federal law as well as state law. The privacy laws of a particular state or other federal laws might impose a stricter privacy standard. If these stricter laws apply and are not superseded by federal preemption rules under the Employee Retirement Income Security Act of 1974, the Plans will comply with the stricter law.

We are required by law to maintain the privacy and security of your Protected Health Information (PHI). Protected Health Information (PHI) is information that is maintained or transmitted by Delta Dental, which may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. We receive, use and disclose your PHI to administer your benefit plan as permitted or required by law.

We must follow the federal and state privacy requirements described that apply to our administration of your benefits and provide you with a copy of this notice. We reserve the right to change our privacy practices when needed and we promptly post the updated notice within 60 days on our website.

PERMITTED USES AND DISCLOSURES OF YOUR PHI

Uses and disclosures of your PHI for treatment, payment or health care operations

Your explicit authorization is not required to disclose information for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. Examples of this include processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers, determine your eligibility for services, billing you or your plan sponsor.

If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or plan sponsor to administer your benefits. As permitted by law, we may disclose PHI to third-party affiliates that perform services on our behalf to administer your benefits. Any third-party affiliates performing services on our behalf has signed a contract agreeing to protect the confidentiality of your PHI and has implemented privacy policies and procedures that comply with applicable federal and state law.

Permitted uses and disclosures without an authorization

We are permitted to disclose your PHI upon your request, or to your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human

Services to investigate or determine our compliance with the law, and when otherwise required by law. We may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Some other examples include: to notify or assist in notifying a family member, another person, or a personal representative of your condition; to assist in disaster relief efforts; to report victims of abuse, neglect or domestic violence to appropriate authorities; for organ donation purposes; to avert a serious threat to health or safety; for specialized government functions such as military and veterans activities; for workers' compensation purposes; and, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting, provided it does not contain genetic information. Information can also be de-identified or summarized so it cannot be traced to you and, in selected instances, for research purposes with the proper oversight.

Disclosures made with your authorization

We will not use or disclose your PHI without your prior written authorization unless permitted by law. If you grant an authorization, you can later revoke that authorization, in writing, to stop the future use and disclosure.

YOUR RIGHTS REGARDING PHI

You have the right to request an inspection of and obtain a copy of your PHI.

You may access your PHI by providing a written request. Your request must include (1) your name, address, telephone number and identification number, and (2) the PHI you are requesting. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We will only maintain PHI that we obtain or utilize in providing your health care benefits. We may not maintain some PHI, such as treatment records or x-rays after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that we do not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed.

You have the right to request a restriction of your PHI.

You have the right to ask that we limit how we use and disclose your PHI; however, you may not restrict our legal or permitted uses and disclosures of PHI. While we will consider your request, we are not legally required to accept those requests that we cannot reasonably implement or comply with during an emergency.

You have the right to correct or update your PHI.

You may request to make an amendment of PHI we maintain about you. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal within 60 days. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your provider to amend your treatment chart or to your employer, if applicable, to amend your enrollment information.

You have rights related to the use and disclosure of your PHI for marketing.

We will obtain your authorization for the use or disclosure of PHI for marketing when required by law. You have the right to withdraw your authorization at any time. We do not use your PHI for fundraising purposes.

You have the right to request or receive confidential communications from us by alternative means or at a different address.

You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes

of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons, certain law enforcement purposes or disclosures made as part of a limited data set. We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another accounting within 12 months.

You have the right to a paper copy of this notice.

A copy of this notice is posted on our website. You may also request that a copy be sent to you.

You have the right to be notified following a breach of unsecured protected health information.

We will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

You have the right to choose someone to act for you.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

COMPLAINTS

You may file a complaint with us and/or with the U.S. Secretary of Health and Human Services if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.

CONTACTS

You may contact us by calling 866-530-9675, or you may write to the address listed below for further information about the complaint process or any of the information contained in this notice.

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330

This notice is effective on and after March 1, 2019.

Our Delta Dental PPO plans are underwritten by these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT. DeltaCare USA is underwritten in these states by these companies: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products. DeltaVision is underwritten by these companies in these states: Delta Dental of California — CA; Delta Dental Insurance Company — AL, DE, DC, FL, GA, LA, MD, MT, NV, NY, PA, TX, UT and WV. DeltaVision is administered by Vision Service Plan (VSP).

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 888-282-9501 (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 888-282-9501 (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 888-282-9501 (TTY: 711)。(Chinese)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 888-282-9501 (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 888-282-9501 (TTY: 711)번으로 연락하십시오. (Korean)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 888-282-9501 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 888-282-9501 (телетайп: 711). (Russian)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نوفر لك من يساعدك في قراءتها. ربما يمكنك أيضاً الحصول على هذا المستند مكتوباً بلغتك للمساعدة المجانية اتصل بـ 888-282-9501 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posibilite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 888-282-9501 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n'est pas le cas, nous pouvons faire en sorte que quelqu'un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l'assistance gratuitement, veuillez appeler le 888-282-9501 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 888-282-9501 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 888-282-9501 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 888-282-9501 (TTY: 711). (Italian)

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、888-282-9501 (TTY: 711) までお問い合わせください。(Japanese)

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 888-282-9501 (Schreibtelefon: 711). (German)

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: 888-282-9501 (TTY: 711). (Persian Farsi)

צי קענט איר לייענען דעם דאזיקן דאקומענט? אויב ניט, עמעצער דאָ קען אייך העלפן אים צו לייענען. עס איז אויך מעגלעך, אז איר קענט באקומען דעם דאזיקן דאקומענט אין אייער שפראך. פֿאַר אומזיסטע הילף קענט איר אַנקלינגען אַט די דאזיקע נומער: 888-282-9501 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bííníghah? Doo bííníghahgóó éí nich'í' yídóółtahígíí nihee hółq. Díí naaltsoos t'áá Diné bizaad k'éhjí ályaaago ałdó' nich'í' ádoolnǫ́łgo bííghah. T'áá jíík'e shíká í'doolwoł nínízingo kojí' béésh holdíílnih 888-282-9501 (TTY: 711) (Navajo)

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.

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ENROLLEE NOTICES

Federal and state laws require enrollees to be notified on a periodic basis about enrollee rights and privacy practices. Below is a summary of the notices that are available under the legal or privacy section of our webpage. To access the most current version and the full text of each notice, please visit our website at deltadentalins.com.

Federal Notices:

- **HIPAA Notice of Privacy Practices (NPP):** Federal regulations require insurance plans to share information about the company's privacy practices. This is called a "Notice of Privacy Practices (NPP)" and should be read when an individual first becomes an enrollee and reviewed at least every three years thereafter.
- **Gramm-Leach-Bliley (GLB):** Financial institutions and insurance companies must describe how demographic and financial information is collected and shared. California requires a state specific notice called the California Financial Privacy Notice, which is described below under the State Notices section.
- **Notice of 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. If you believe 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.

- **Language Assistance Notice and Survey:** We provide phone interpretation to callers who do not speak English. In California, we will also provide, on request, a translated copy of certain vital documents in either Spanish or Chinese. In Maryland and Washington DC, enrollees may receive grievance materials in Spanish or Chinese.

State Notices:

- **CA Financial Privacy Notice:** This notice to Californians describes our demographic and financial information collection and sharing practices. It is similar to the Gramm-Leach-Bliley (GLB) notice described above.
- **CA Grievance Process:** This notice describes our procedure for processing and resolving enrollee grievances and gives the address and phone number to make a complaint. Californians are encouraged to read this notice when they first enroll and annually thereafter.
- **CA Timely Access to Care:** California law requires health plans to provide timely access to care. This law sets limits on how long enrollees must wait to get appointments and telephone assistance.
- **CA Tissue and Organ Donations:** This notice informs subscribers of the societal benefits of organ donation and the methods they can use to become organ and/or tissue donors. California regulations require every health plan to provide this information upon enrollment and annually thereafter.

- **CA Annual Deductible and OOP Max Accrual Balances:** California law requires health plans to provide enrollees with up-to-date accrual balances towards their annual deductible and out-of-pocket maximum for every month benefits were used until the accrual balances are met. Enrollees have the right to request their most up-to-date accrual balance from the health plan at any time.
- **CA Request Confidential Communications:** This notice informs subscribers of methods of contacting the plan when there is a need or desire to provide and alternative address to received protected health information. Users may also choose to use the “Request for Confidential Communication” form when submitting such request.

For questions concerning the notices, please contact us at 866-530-9675. You may also write to us at:

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330

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

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023
888-282-9501

In California, DeltaCare USA is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company.