DeltaCare® USA

Dental Health Care Plan

Evidence of Coverage

AZ15B

Underwritten by:
Alpha Dental of Arizona, Inc.
18000 Studebaker Road, Suite 530
Cerritos, CA 90703

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

deltadentalins.com

EVIDENCE OF COVERAGE

Introduction

DeltaCare® USA Dental Health Care Plan

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

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

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

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

Contract
The Benefit explanations contained in this EOC and the attachments are subject to all provisions of the Contract. In the event there is a conflict between the EOC and the Contract, the Contract prevails. This document is not a Summary Plan Description under the Employee Retirement Income Security Act ("ERISA").

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

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

Notice
This EOC is a summary of Your dental Plan. This information is not a guarantee of covered Benefits, services or payments.

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

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

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

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Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Effective Date: The date the Contract or coverage begins.

Emergency Services: Dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing You in serious jeopardy. Emergency dental care is limited to palliative treatment for the elimination of dental pain.

Enrollee ("Primary Enrollee"): Employee or a Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Grace Period: A period of no less than 31 days after the Premium payment is due under the Contract, in which a payment may be made and during which coverage will continue in effect, subject to the Premium payment by the end of the Grace Period.

Open Enrollment Period: The period the Contractholder has established for You to make changes in coverage selections for the next Contract Term.

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

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

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

Premium: Payment made in consideration of dental coverage.

Schedules: Dental services and procedures and applicable limitations and exclusions included under Your Plan and described in:
- *Schedule A, Description of Benefits and Copayments,* and
- *Schedule B, Limitations and Exclusions of Benefits*

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

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

Spouse: An individual who is a partner of the Primary Enrollee as:
- Defined and as may be required to be treated as a Spouse by the laws of the state where the Contract is issued and delivered;
- Defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides; or
- May be recognized by the Contractholder.

Eligibility and Enrollment - When Coverage Begins

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

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

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

acquire dependent status. Coverage for newborns, adopted children and children placed for adoption is automatic for 31 days. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the date of placement for adoption or final decree of adoption, whichever occurs first. Notice of birth, adoption or adoption placement and payment of the appropriate Premium must be received within 31 days after the date of birth, adoption or adoption placement for coverage to continue beyond 31 days.

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

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

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

Overage Children

An overage unmarried dependent child may be eligible if:

1) the child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that began prior to reaching the limiting age;
2) the child is chiefly dependent on You for support; and

- Proof of disability is provided within 30 days of the limiting age. Proof of disability will not be required more than one (1) time per year following a two year period after the Dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Primary Enrollee for support because of a physically or mentally disabling injury, illness or condition that began before the Dependent reaches the limiting age.

Enrollment Requirements

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

If You are responsible for Your Premium:

- All Dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period or Special Enrollment Period.
-

If You elect Dependent coverage, You must enroll all of Your Dependent Enrollees for coverage.

An exception for enrolling Dependent Enrollees within 30 days after they become eligible applies for certain young children. The eligibility date for such children may be delayed as outlined in the *Eligibility Requirements* section.

You:

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

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

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

Special Enrollment Periods - Enrollment Changes

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

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

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

How to use the DeltaCare USA Program

Choice of Contract Dentist

We will provide Your Plan with Contract Dentists at convenient locations. Upon enrollment, You must select a Contract Dentist from the list of Dentists provided at deltadentalins.com. If you fail to select a Contract Dentist, or the Contract Dentist selected becomes unavailable, We will request the selection of another Contract Dentist or will assign You to another Contract Dentist.

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

We will provide You written notice of the assignment to another Contract Dentist provided Your Contract Dentist:
- No longer taking further enrollment;
- No longer participates in the Plan; or
- Requests, for good cause, that You or Your Dependents be re-assigned to another Contract Dentist.

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

Coordination of Care and Referrals

Services for Benefits must be provided by the assigned Contract Dentist. Specialist Services, obtained from a Contract Orthodontist or Contract Specialist, must be referred by Your Contract Dentist.

We have no obligation or liability with respect to services provided by Out-of-Network Dentists, with the exception of Emergency

Services or Specialist Services referred by a Contract Dentist and authorized by Us. All authorized Specialist Services claims will be paid less any applicable Copayments.

Contract Dentist Termination

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

Upon termination of a Contract Dentist's agreement, We will be liable for the completion of dental treatment begun prior to the termination of the agreement. For example, the terminating Contract Dentist will complete:

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

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

Benefits, Limitations and Exclusions

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

Copayments and Other Charges

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

Emergency Services
If you have a dental emergency, You should contact Your Contract Dentist whenever possible. Contract Dentists maintain a twenty-four (24) hour Emergency Services system seven (7) days a week. If You are unable to reach the Contract Dentist for Emergency Services, contact Customer Service at 800-422-4234 for assistance in obtaining urgent care.

You may seek treatment from a Dentist other than Your Contract Dentist with no referral during non-business hours, or if You require Emergency Services and are 35 miles or more from Your Contract Dentist. You are only responsible for the Copayment(s) for any treatment received relating to the emergency.

Benefits for Emergency Services not provided by a Contract Dentist are limited to a maximum of $100.00 per emergency, per Enrollee, less the applicable Copayment. If this maximum is exceeded, You are responsible for any charges for services by a Dentist other than Your Contract Dentist. You must return to Your Contract Dentist for any necessary follow-up care.

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

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

Claims for Reimbursement

Claims for covered Emergency Services or Specialist Services should be submitted for payment within 90 days of receiving treatment. Claims must be received within one (1) year of treatment date. The address for claims submission is:

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

Claim Forms
Upon receipt of notice of claim, We will furnish to the claimant such forms as are usually furnished for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Contract as to proof of loss upon submitting, within the time fixed in the *Proof of Loss* section for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Notice of Claim
Written notice of a claim must be provided to Us within 20 days after the occurrence or start of the loss on which the claim is based.

Proof of Loss
Claims must be sent within 90 days of the end of treatment. Valid claims received after this time period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. Except in the absence of legal capacity, all claims must be received no later than one year from the time submittal of the claim is otherwise required.

Time Payment of Claims
Indemnities payable under this Contract for any loss other than loss for which this Contract provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Contract provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Coordination of Benefits
If You or Your Dependent Enrollee is an insured or certificate holder under an indemnity health insurance policy which provides benefits for the same treatment as a prepaid dental plan, the indemnity health insurance policy, if issued after September 15, 1989, will pay benefits to You or Your Dependent Enrollee or the assignee thereof, without regard to the existence of this prepaid dental plan.

The determination of which policy or program is primary will be governed by the rules stated in the Contract.

The indemnity plan insurer is not obligated to pay any amount for a procedure covered without charge to You or to pay in excess of the amount of Your copayment obligation under this prepaid

dental plan. In the event that the Your obligation under this prepaid dental plan has been met, then the indemnity insurer will remit any payments due to You.

You must provide to Us and We may release to or obtain from any insurance company or other organization, any information about You or Your Dependent Enrollee that is needed to administer coordination of benefits. We will, in Our sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid will be deemed to be Benefits under this Contract. We will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as We choose, the amount of any Benefits paid by Us which exceeds Our obligations under these coordination of benefit provisions.

Quality Management Department
P.O. Box 1860
Alpharetta, GA 30023

Enrollee Complaint Procedure

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

Quality Management Department
P.O. Box 1860
Alpharetta, GA 30023

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

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) You must file a request for review (a complaint) with Us within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review will be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon

request and free of charge, We will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, 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.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations, the quality management coordinator will provide You an acknowledgment of receipt of the complaint. Certain complaints may require that You be referred to a Dentist for a clinical evaluation of the dental services provided.

We will make a determination, in writing, within 30 days of receipt of a complaint or will provide a written explanation if additional time is required to report on the complaint. A review of the decision will be undertaken if a written request for an appeal of the determination is made within 30 days of the date of the written determination. We will undertake a full and fair review upon request. We may require additional documents in making such a review. A written response will be provided to You within 30 days after receipt of Your appeal and supporting documentation or a written explanation if additional time is required to issue the results.

We will review appeals based upon the terms and conditions of this Contract. The following levels of review will be available to You:

Expedited Dental Review
Informal Reconsideration
Formal Appeal
External Independent Review

A separate Health Care Insurer Appeals Process Information Packet, which describes the appeal process You may pursue, is included with the Evidence of Coverage at initial enrollment and subsequently upon request to Us.

If Your Plan is subject to ERISA, You may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if You have questions about Your rights under ERISA. You may also bring a civil action under

section 502(a) of ERISA. The U.S. Department of Labor may be contacted at:

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

Renewal and Termination of Benefits

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

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

We are not obligated to continue to provide Benefits to You or Your Dependents except for completion of dental treatment started when this Plan was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, Your or Your Dependent Enrollees enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately
   a) Upon loss of eligibility as described in this EOC; or
   b) If You engage in conduct detrimental to safe operations and the delivery of services while receiving services from a Contract Dentist.
2) Upon 15 days written notice if
   a) the premiums are not paid by or on behalf of You or Your Dependent Enrollees on the date due. However You and Your Dependent Enrollees may continue to receive Benefits during the 15-day period and may be reinstated during the term of this Contract upon payment of any unpaid premium; or
   b) You or Your Dependent Enrollees knowingly commit or permit another person to commit fraud or deception in obtaining Benefits under the Program;
3) Upon 30 days written notice if
   a) the Contract is terminated or not renewed;
   b) You fail to pay Copayments. However, You may be reinstated during the term of the Contract upon payment of all delinquent charges; or

c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. We must show that We have, in good faith, provided You and Your Dependent Enrollees with the opportunity to select an alternative Contract Dentist. If the You or Your Dependent Enrollees establish a history of unsatisfactory relationships, We will notify You in writing, at least 30 days in advance, that We consider the dentist- patient relationships to be unsatisfactory. We will also specify the changes that are necessary in order to avoid cancellation, and show that You failed to make these changes;

The Contractholder will provide You with 15 days advance notice prior to cancellation or discontinuance of the Plan.

Cancellation of Your enrollment will automatically cancel the enrollment of any of Your Dependent Enrollees.

General Provisions

Change of Beneficiary
Unless You make an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to You and the consent of the beneficiary or beneficiaries will not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

Compliance with Administrative Simplification, Security and Privacy Regulations
The parties will comply in all respects with applicable federal, state and local laws and regulations relating to administrative simplification, security and privacy of individually identifiable information including executing any agreements as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The parties agree that this Contract will incorporate terms as necessary and as applicable to execute the required agreements (i.e. business associate agreement) to comply with federal regulations issued under the HIPAA and HITECH Act or to comply with any other enacted administrative simplifications, security or privacy laws or regulations.

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

Entire Contract; Changes
All legal questions about the Contract will be governed by the state where the Contract was entered into and is to be performed. Any part of the Contract which, on its effective date, is in conflict with the laws of the state in which the insured resides or federal law is hereby amended to conform to the minimum requirements of such laws.

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

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

Legal Actions
No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor will an action be brought at all unless brought within two (2) years from expiration of the time within which proof of loss is required by the Contract.

Misstatements on Application; Effect
In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the Contract, all statements made by You will be deemed representations and not warranties. No such statement will be used in defense to a claim, unless it is contained in a written application.

Physical Examinations and Autopsy

We, at Our expense, will have the right and opportunity to examine You when and as often as it may reasonably required during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Processing Policies
The Schedules explain the services covered under the Plan. Contract Dentists, Contract Orthodontists and Contract Specialists use professional judgment to determine appropriate services for You. Benefits performed by Contract Dentists, Contract Orthodontists and Contract Specialists are provided subject to any Copayments. You may contact Our Customer Service at 800-422-4234 for information regarding the dental care guidelines for DeltaCare USA.

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

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

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

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

Continuation of Coverage under USERRA
- As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if You are covered on the date Your USERRA leave of absence begins, You may continue dental coverage for Yourself and any covered Dependents. Continuation of coverage under USERRA may not extend beyond the earlier of:
- Twenty-four (24) months, beginning on the date the leave of absence begins, or;
- The date You fail to return to work within the time required by USERRA.

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

Continuation of Coverage under COBRA
The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides a way for You to continue coverage for a period of time when employer coverage is lost. COBRA does not apply to all companies, only those that meet certain size guidelines. See Your Human Resources Department or website for complete information. We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

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

We:
- 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)
- 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 Customer Service at 800-471-9925.

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

DeltaCare USA
18000 Studebaker Road, Suite 530
Cerritos, CA 90703
Telephone Number: 866-530-9675

Website Address: deltadentalins.com

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

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

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

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the Contract Dentist subject to the *Limitations and Exclusions* of the Plan. Please refer to *Schedule B* for further clarification of Benefits. **You should discuss all treatment options with Your Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2024 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	YOU PAY
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - comprehensive series of radiographic images - *limited to 1 series every 24 months, or more frequently if medically necessary*	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	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months, or more frequently if medically necessary*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0396	3D printing of a 3D dental surface scan - *limited to one series every 24 months*	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost

D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period, or more frequently if medically necessary*	$5.00
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period, or more frequently if medically necessary*	$5.00
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *1 D1206 or D1208 per 6 month period, or more frequently if medically necessary*	No Cost
D1208	Topical application of fluoride - excluding varnish - *1 D1206 or D1208 per 6 month period, or more frequently if medically necessary*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth	$15.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	$15.00
D1353	Sealant repair - per tooth	$15.00

D1354	Application of caries arresting medicament - per tooth - *child to age 19; 1 per 6 month period, or more frequently if medically necessary*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$70.00
D1516	Space maintainer - fixed - bilateral, maxillary	$70.00
D1517	Space maintainer - fixed - bilateral, mandibular	$70.00
D1520	Space maintainer - removable - unilateral - per quadrant	$80.00
D1526	Space maintainer - removable - bilateral, maxillary .	$80.00
D1527	Space maintainer - removable - bilateral, mandibular	$80.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$15.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$15.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$15.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$15.00
D1557	Removal of fixed bilateral space maintainer - maxillary	$15.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$15.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	$70.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, You may be charged an additional $100.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old, or more frequently if medically necessary.

D2140	Amalgam - one surface, primary or permanent	$8.00
D2150	Amalgam - two surfaces, primary or permanent	$12.00
D2160	Amalgam - three surfaces, primary or permanent ..	$18.00
D2161	Amalgam - four or more surfaces, primary or permanent	$22.00
D2330	Resin-based composite - one surface, anterior	$22.00
D2331	Resin-based composite - two surfaces, anterior	$26.00

D2332	Resin-based composite - three surfaces, anterior ...	$30.00
D2335	Resin-based composite - four or more surfaces (anterior)	$55.00
D2390	Resin-based composite crown, anterior	$65.00
D2391	Resin-based composite - one surface, posterior	$65.00
D2392	Resin-based composite - two surfaces, posterior ...	$75.00
D2393	Resin-based composite - three surfaces, posterior .	$85.00
D2394	Resin-based composite - four or more surfaces, posterior	$95.00
D2510	Inlay - metallic - one surface	$185.00
D2520	Inlay - metallic - two surfaces	$195.00
D2530	Inlay - metallic - three or more surfaces	$205.00
D2542	Onlay - metallic - two surfaces	$200.00
D2543	Onlay - metallic - three surfaces	$210.00
D2544	Onlay - metallic - four or more surfaces	$230.00
D2610	Inlay - porcelain/ceramic - one surface	$310.00
D2620	Inlay - porcelain/ceramic - two surfaces	$345.00
D2630	Inlay - porcelain/ceramic - three or more surfaces ..	$365.00
D2642	Onlay - porcelain/ceramic - two surfaces	$340.00
D2643	Onlay - porcelain/ceramic - three surfaces	$375.00
D2644	Onlay - porcelain/ceramic - four or more surfaces ..	$395.00
D2650	Inlay - resin-based composite - one surface	$210.00
D2651	Inlay - resin-based composite - two surfaces	$235.00
D2652	Inlay - resin-based composite - three or more surfaces	$270.00
D2662	Onlay - resin-based composite - two surfaces	$265.00
D2663	Onlay - resin-based composite - three surfaces	$290.00
D2664	Onlay - resin-based composite - four or more surfaces	$335.00
D2710	Crown - resin-based composite (indirect)	$185.00
D2712	Crown - 3/4 resin-based composite (indirect)	$185.00
D2720	Crown - resin with high noble metal	$335.00
D2721	Crown - resin with predominantly base metal	$235.00
D2722	Crown - resin with noble metal	$275.00
D2740	Crown - porcelain/ceramic	$395.00
D2750	Crown - porcelain fused to high noble metal	$395.00

D2751	Crown - porcelain fused to predominantly base metal	$295.00
D2752	Crown - porcelain fused to noble metal	$335.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$395.00
D2780	Crown - 3/4 cast high noble metal	$395.00
D2781	Crown - 3/4 cast predominantly base metal	$295.00
D2782	Crown - 3/4 cast noble metal	$335.00
D2783	Crown - 3/4 porcelain/ceramic	$395.00
D2790	Crown - full cast high noble metal	$395.00
D2791	Crown - full cast predominantly base metal	$295.00
D2792	Crown - full cast noble metal	$335.00
D2794	Crown - titanium and titanium alloys	$395.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$20.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$20.00
D2920	Re-cement or re-bond crown	$20.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$55.00
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$75.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$75.00
D2931	Prefabricated stainless steel crown - permanent tooth	$75.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$85.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	$20.00
D2941	Interim therapeutic restoration - primary dentition	$20.00
D2949	Restorative foundation for an indirect restoration	$80.00
D2950	Core buildup, including any pins when required	$80.00
D2951	Pin retention - per tooth, in addition to restoration	$15.00
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$110.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$80.00

D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$95.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$70.00
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework.	$60.00
D2976	Band stabilization - three surfaces, primary or permanent	$18.00
D2980	Crown repair necessitated by restorative material failure	$30.00
D2981	Inlay repair necessitated by restorative material failure	$30.00
D2982	Onlay repair necessitated by restorative material failure	$30.00
D2983	Veneer repair necessitated by restorative material failure	$30.00
D2989	Excavation of a tooth resulting in the determination of non-restorability	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$15.00
D2991	Application of hydroxyapatite regeneration medicament - *limited to permanent molars through age 15*	$15.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	$5.00
D3120	Pulp cap - indirect (excluding final restoration)	$5.00
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	$50.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$45.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$60.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$60.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$125.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$215.00

D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$365.00
D3331	Treatment of root canal obstruction; non-surgical access	$80.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$80.00
D3333	Internal root repair of perforation defects	$80.00
D3346	Retreatment of previous root canal therapy - anterior	$155.00
D3347	Retreatment of previous root canal therapy - premolar	$245.00
D3348	Retreatment of previous root canal therapy - molar	$395.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$80.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$55.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$55.00
D3410	Apicoectomy - anterior	$155.00
D3421	Apicoectomy - premolar (first root)	$165.00
D3425	Apicoectomy - molar (first root)	$175.00
D3426	Apicoectomy (each additional root)	$100.00
D3430	Retrograde filling - per root	$75.00
D3450	Root amputation - per root	$85.00
D3471	Surgical repair of root resorption - anterior	$155.00
D3472	Surgical repair of root resorption - premolar	$155.00
D3473	Surgical repair of root resorption - molar	$155.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$155.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$155.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$155.00

D3920	Hemisection (including any root removal), not including root canal therapy	$75.00
D3921	Decoronation or submergence of an erupted tooth	$14.00

D4000-D4999 V. PERIODONTICS

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$160.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$95.00
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	$160.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$95.00
D4245	Apically positioned flap	$175.00
D4249	Clinical crown lengthening - hard tissue	$150.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$385.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$308.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$235.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$85.00
D4270	Pedicle soft tissue graft procedure	$235.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$90.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$235.00

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	$235.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$60.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period, or more frequently if medically necessary*	$5.00
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$60.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$45.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
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 of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	$365.00
D5120	Complete denture - mandibular	$365.00
D5130	Immediate denture - maxillary	$385.00
D5140	Immediate denture - mandibular	$385.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$325.00

D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$325.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$395.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$395.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$325.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$325.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$395.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$395.00
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 ...	$445.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$445.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$325.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$325.00
D5410	Adjust complete denture - maxillary	$18.00
D5411	Adjust complete denture - mandibular	$18.00
D5421	Adjust partial denture - maxillary	$18.00
D5422	Adjust partial denture - mandibular	$18.00
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 (each tooth)	$35.00
D5611	Repair resin partial denture base, mandibular	$55.00
D5612	Repair resin partial denture base, maxillary	$55.00
D5621	Repair cast partial framework, mandibular	$55.00

D5622	Repair cast partial framework, maxillary	$55.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$55.00
D5640	Replace broken teeth - per tooth	$45.00
D5650	Add tooth to existing partial denture	$45.00
D5660	Add clasp to existing partial denture - per tooth	$55.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$180.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$180.00
D5710	Rebase complete maxillary denture	$105.00
D5711	Rebase complete mandibular denture	$105.00
D5720	Rebase maxillary partial denture	$105.00
D5721	Rebase mandibular partial denture	$105.00
D5725	Rebase hybrid prosthesis	$105.00
D5730	Reline complete maxillary denture (chairside)	$60.00
D5731	Reline complete mandibular denture (chairside)	$60.00
D5740	Reline maxillary partial denture (chairside)	$60.00
D5741	Reline mandibular partial denture (chairside)	$60.00
D5750	Reline complete maxillary denture (laboratory)	$95.00
D5751	Reline complete mandibular denture (laboratory)	$95.00
D5760	Reline maxillary partial denture (laboratory)	$95.00
D5761	Reline mandibular partial denture (laboratory)	$95.00
D5765	Soft liner for complete or partial removable denture - indirect	$95.00
D5820	Interim partial denture (including retentive/ clasping materials, rests, and teeth), maxillary - *limited to 1 in any 12 consecutive months*	$125.00
D5821	Interim partial denture (including retentive/ clasping materials, rests, and teeth), mandibular - *limited to 1 in any 12 consecutive months*	$125.00
D5850	Tissue conditioning, maxillary	$30.00
D5851	Tissue conditioning, mandibular	$30.00

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])

- When a crown and/or pontic exceeds six units in the same treatment plan, You may be charged an additional $100.00 per unit, beyond the 6th unit.
- 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	$395.00
D6211	Pontic - cast predominantly base metal	$295.00
D6212	Pontic - cast noble metal	$335.00
D6240	Pontic - porcelain fused to high noble metal	$395.00
D6241	Pontic - porcelain fused to predominantly base metal	$295.00
D6242	Pontic - porcelain fused to noble metal	$335.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$335.00
D6245	Pontic - porcelain/ceramic	$395.00
D6250	Pontic - resin with high noble metal	$335.00
D6251	Pontic - resin with predominantly base metal	$235.00
D6252	Pontic - resin with noble metal	$275.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$345.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$365.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$295.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$305.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$195.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$205.00
D6606	Retainer inlay - cast noble metal, two surfaces	$225.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$235.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$340.00

D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$375.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$300.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$310.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$200.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$210.00
D6614	Retainer onlay - cast noble metal, two surfaces	$220.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$240.00
D6720	Retainer crown - resin with high noble metal	$335.00
D6721	Retainer crown - resin with predominantly base metal	$235.00
D6722	Retainer crown - resin with noble metal	$275.00
D6740	Retainer crown - porcelain/ceramic	$395.00
D6750	Retainer crown - porcelain fused to high noble metal	$395.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$295.00
D6752	Retainer crown - porcelain fused to noble metal	$335.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$395.00
D6780	Retainer crown - 3/4 cast high noble metal	$395.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$295.00
D6782	Retainer crown - 3/4 cast noble metal	$335.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$395.00
D6784	Retainer crown - 3/4 titanium and titanium alloys	$395.00
D6790	Retainer crown - full cast high noble metal	$395.00
D6791	Retainer crown - full cast predominantly base metal	$295.00
D6792	Retainer crown - full cast noble metal	$335.00
D6930	Re-cement or re-bond fixed partial denture	$25.00
D6940	Stress breaker	$50.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$70.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - primary tooth	$10.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$14.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$55.00
D7220	Removal of impacted tooth - soft tissue	$70.00
D7230	Removal of impacted tooth - partially bony	$95.00
D7240	Removal of impacted tooth - completely bony	$120.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$140.00
D7250	Removal of residual tooth roots (cutting procedure)	$45.00
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	$140.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$130.00
D7280	Exposure of an unerupted tooth	$120.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$120.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7284	Excisional biopsy of minor salivary glands - *does not include pathology laboratory procedures*	$40.00
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$40.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$100.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$100.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$120.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$120.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost

D7471	Removal of lateral exostosis (maxilla or mandible) .	$100.00
D7472	Removal of torus palatinus	$100.00
D7473	Removal of torus mandibularis	$100.00
D7509	Marsupialization of odontogenic cyst	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	$25.00
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost
D7970	Excision of hyperplastic tissue - per arch	$80.00
D7971	Excision of pericoronal gingiva	$80.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.

- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

	The Benefit for pre-treatment records and diagnostic services includes:	$200.00
D0210	Intraoral - comprehensive series of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intraorally or extraorally	
D0396	3D printing of a 3D dental surface scan	No Cost
D0470	Diagnostic casts	
D0801	3D dental surface scan - direct	
D0802	3D dental surface scan - indirect	
D0803	3D facial surface scan - direct	
D0804	3D facial surface scan - indirect	

	The Benefit for post-treatment records includes:	$70.00
D0210	Intraoral - comprehensive series of radiographic images	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	$1,150.00
D8020	Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$1,150.00
D8030	Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,150.00
D8040	Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,350.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$1,900.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,900.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$2,100.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative treatment of dental pain - per visit	$20.00
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

D9222	Deep sedation/general anesthesia - first 15 minutes	$80.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$80.00
D9239	Intravenous moderate (conscious) sedation/ analgesia - first 15 minutes	$80.00
D9243	Intravenous moderate (conscious) sedation/ analgesia - each subsequent 15 minute increment	$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$25.00
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	$35.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	$0.00
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$105.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$105.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$105.00
D9951	Occlusal adjustment, limited	$55.00
D9952	Occlusal adjustment, complete	$105.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00

D9986	Missed appointment - *includes failed appointment without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *includes failed appointment without 24 hour notice - per 15 minutes of appointment time*	$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

If services for a listed procedure are performed by Your Contract Dentist, You pay the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the Contract Dentist, must be authorized by Us. You pay the Copayment specified for such services. Questions regarding the DeltaCare USA Plan should be directed to Customer Service at 800-422 4234.

SCHEDULE B

Limitations and Exclusions of Benefits

Limitations

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If You accept a treatment plan from the general Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, You may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age 13 following an attempt by the Contract Dentist to treat the child and upon Authorization by Us, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. Your cost for receiving orthodontic treatment when coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's submitted 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.
6. Orthodontic treatment in progress is available to You, if at the time of Your original effective date, You are in active treatment started under Your previous group dental plan, as long as You continue to be eligible under the DeltaCare USA Plan. Active treatment means tooth movement has begun. You are responsible for all Copayments and fees subject to the provisions of Your prior dental plan. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

7. Benefits for a soft tissue management Plan are limited to those parts which are listed covered services listed on *Schedule A, Description of Benefits and Copayments.*
8. 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.
9. Coverage for orthodontic treatment is limited to conventional orthodontic services, which includes clear aligner therapy (e.g., Invisalign™ and Sure Smile™). We consider lingual brackets, clear (composite or ceramic) brackets to be specialized services. When treatment using lingual brackets or clear (composite or ceramic) brackets is provided, We will make an allowance for conventional orthodontic services. You are responsible for Your Copayment for the conventional orthodontic treatment plus the additional fees related to the specialized services (lingual brackets or clear brackets).

Exclusions

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) when the affected teeth have not reached completion of dental and skeletal growth.
5. The replacement of lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restorations if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Procedures that may include:
   a. precious metal for removable appliances;
   b. metallic or permanent soft bases for complete dentures;
   c. porcelain denture teeth;
   d. precision abutments for removable partials or fixed partial dentures including but not limited to overlays and related specialized appliances; and/or
   e. personalization and characterization of complete and partial dentures.
8. Consultations for non-covered Benefits.
9. Dental services received from any dental facility other than the Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Evidence of Coverage.

10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
11. Prescription drugs.
12. Dental expenses incurred in connection with any dental or orthodontic 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 unless qualified for the orthodontic treatment in progress provision.
13. Lost, stolen or broken orthodontic appliances.
14. Changes in orthodontic treatment necessitated by accident of any kind.
15. Myofunctional and parafunctional appliances and/or therapies with the exception of procedures D9944 (Occlusal guard - hard appliance, full arch), D9945 (Occlusal guard - soft appliance, full arch) and D9946 (Occlusal guard - hard appliance, partial arch);
16. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
17. Any part of a preventive or soft tissue management program which is not a listed covered service in *Schedule A, Description of Benefits and Copayments*.
18. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.

DELTA DENTAL®

Non-Discrimination Disclosure

Discrimination is Against the Law

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

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

if such denial or limitation results in discriminating against a transgender individual.

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

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

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

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 1-800-422-4234 (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 1-800-422-4234 (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 1-800-422-4234 (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 1-800-422-4234 (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、1-800-422-4234 (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: 1-800-422-4234 (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: 1-800-422-4234 (TTY: 711). (Persian Farsi)

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

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

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

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

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

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

צי קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט,עמעצער דאָ קען איר העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אַז איר קענט באַקומען דעם דאָזיקן דאָקומענט אין אײַער שפּראַך. פֿאַר אומזיסטע הילף קענט איר אַנקלינגען אַט די דאָזיקע נומער: 1-800-422-4234 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'į' yídóołtahígíí nihee hóló. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaagoałdó' nich'į' ádoolnį́łgo bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojį' béésh holdíílnih 1-800-422-4234 (TTY: 711) (Navajo)

Alpha Dental of Arizona, Inc,
Administered by Delta Dental Insurance Company

Health Care Insurer Appeals Process Information Packet

CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS WE MAKE ABOUT YOUR HEALTH CARE.

Getting Information About the Health Care Appeals Process Help in Filing an Appeal, Standardized Forms, and Consumer Assistance From the Arizona Insurance Department

We will send You a copy of this information packet when You first receive Your policy, and within five (5) business days after We receive Your request for an appeal. When Your dental coverage is renewed, We will also send You a separate statement You that You can request another copy of this packet. We will also send a copy of this packet to You or Your treating provider at any time upon request. Just call Our Customer Service at 800-422-4234 and ask for a copy of this packet.

At the end of this packet, You will find forms You to use for Your appeal. The Arizona Insurance Department ("Department") developed these forms to help Enrollees who want to file a health care appeal. You are not required to use them. We cannot reject Your appeal if You do not use them. If You need help in filing an appeal, or You have questions about the appeals process, You may call the Department's Consumer Assistance Office at 602-364-2499 or 800-325-2548) or call Us at 800-422-4234.

When You May Appeal

When We do not authorize or approve a service or pay for a claim, We must notify You of Your right to appeal that decision. Your notice may come directly from Us or through Your treating provider.

Decisions You Can Appeal

You can appeal the following decisions:

- We do not approve a service that You or Your treating provider has requested.
- We do not pay for a service that You have already received.
- We do not authorize a service or pay for a claim because We say that it is not "medically necessary".
- We do not authorize a service or pay for a claim because We say that it is not covered
  under Your dental plan, and You believe it is covered.
- We do not notify You, within ten (10) business days of receiving Your request, whether or not We will authorize a requested service.
- We do not authorize a referral to a specialist.
-

Decisions You Cannot Appeal

You cannot appeal the following decisions:

- You disagree with Our decision as to the amount of "submitted fee charges".
- You disagree with how We are coordinating benefits when You have health insurance with more than one (1) insurer.
- You disagree with how We have applied Your claims or services to Your plan deductible.
- You disagree with the amount of coinsurance or copayments that You paid.

- You disagree with Our decision to issue or not issue a dental plan contract to You.
- You disagree with any rate increases You may receive under Your insurance policy.
- You believe We have violated the Arizona Insurance Code.

If You disagree with a decision that is not appealable according to this list, You may still file a complaint with the Department, Consumer Affairs Division, 100 N. 15th Avenue, Suite 260, Phoenix, AZ 85007-2630.

Who May File An Appeal?

Either You or Your treating provider can file an appeal on Your behalf. At the end of this packet is a form that You may use for filing Your appeal. You are not required to use this form and can send Us a letter with the same information. If You decide to appeal Our decision to deny authorization for a service, You should tell Your treating provider so the provider can help You with the information You need to present Your case.

Description of the Appeals Process

There are two types of appeal - an expedited appeal for urgent matters and a standard appeal. Each type of appeal has three levels. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of the patient's condition.

Expedited Appeals (*urgently needed services not yet received*)	**Standard Appeals** *(non-urgent services or denied claims)*
Level 1: Expedited Medical Review	Informal Reconsideration
Level 2: Expedited Appeal	Formal Appeal
Level 3: Expedited External Independent Medical Review	External Independent Medical Review

We make the decisions at Level 1 and Level 2. An outside reviewer, who is completely independent from Us, makes Level 3 decisions. You are not responsible to pay the costs of the external review if You choose to appeal to Level 3.

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Level 1: Expedited Medical Review

Your request:

You may obtain an Expedited Medical Review of Your denied request for a service that has not already been provided if:

- You have dental coverage with Us;
- We denied Your request for a covered service, and
- Your treating provider certifies in writing and provides supporting documentation that the time required to process Your request through the Informal Reconsideration and Formal Appeal process (about 60 days) is likely to cause a significant negative change in Your medical condition. At the end of this packet is a form that Your provider may use for this purpose. Your provider may also send a letter or make up a form with similar information. Your treating

provider must send the certification and documentation to:

Quality Management Department
P.O. Box 1860
Alpharetta, GA 30023
800-422-4234, Fax: 770-641-5389

Our decision: We have one (1) business day after We receive the information from Your treating provider to decide whether We should change Our decision and authorize Your requested service. Within that same business day, We must call and tell You and Your treating provider, and mail You Our decision in writing. The written decision must explain the reasons for Our decision and tell You the documents on which We based Our decision.

If We deny Your request: You may immediately appeal to Level 2, Expedited Appeal.

If We grant Your request: We will authorize the service and the appeal is over.

If We refer Your case to Level 3: We may decide to skip Level 1 and Level 2 and send Your case straight to an independent reviewer at Level 3.

Level 2: Expedited Appeal

Your request: If We deny Your request at Level 1, You may request an Expedited Appeal. After You receive Our Level 1 denial, Your treating provider *must immediately* send Us a written request (to the same person and address listed above under Level 1) to tell Us You are appealing to Level 2. To help Your appeal, Your provider should also send us any information (that the provider hasn't already sent Us) to show why You need the requested service.

Our decision: We have three (3) business days after We receive the request to make Our decision.

If We deny Your request: You may immediately appeal to Level 3, Expedited External, Independent Review.

If We grant Your request: We will authorize the service and the appeal is over.

If We refer Your case to Level 3: We may decide to skip Level 2 and send Your case straight to an independent reviewer at Level 3.

Level 3: Expedited External, Independent Review

Your request: You may appeal to Level 3 only after You have appealed through Levels 1 and 2. You have five (5) business days after You receive Our Level 2 decision to send Us Your written request for an Expedited External, Independent Review. Send Your request and any supporting information to:

Quality Management Department
P.O. Box 1860
Alpharetta, GA 30023
800-422-4234, Fax: 770-641-5389

Neither You nor Your treating provider is responsible for the cost of the external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in Your case:

(1) Medical Necessity: These are cases where We have decided not to authorize a service because We think the services You (or Your treating provider) are asking for, are not medically necessary to treat Your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent reviewer organization ("IRO") that is procured by the Department and not connected with Us. The IRO must be a provider who typically manages the condition under review.

(2) Contract Coverage: These are cases where We have denied coverage because We believe the requested service is not covered under Your dental plan. For contract coverage cases, the Department will be the independent reviewer.

Medical Necessity Cases

Within one (1) business day of receiving Your request, We must:

- Mail a written acknowledgement of Your request to the Director of Insurance ("Director"), You, and Your treating provider; and
- Send the Director:
  - Your request for review;
  - Your dental plan;
  - evidence of coverage or similar document;
  - all medical (dental) records and supporting documentation used to render Our decision;
  - a summary of the applicable issues including a statement of Our decision;
  - the criteria used and clinical reasons for Our decision;
  - and the relevant portions of Our utilization review guidelines.

We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within two (2) business days of receiving Our information, the Director must send all the submitted information to an external IRO.

Within 72 hours of receiving the information, the IRO must make a decision and send the decision to the Director.

Within one (1) business day of receiving the IRO's decision, the Director must mail a notice of the decision to You, Your treating provider, and Us.

The decision (medical necessity): If the IRO decides that We should provide the service, We must authorize the service. If the IRO agrees with Our decision to deny the service, the appeal is over. Your only further option is to pursue Your claim in court.

Contract Coverage Cases

Within one (1) business day of receiving Your request, We must:

- Mail a written acknowledgement of Your request to the Director, You, and Your treating provider; and
- Send the Director:
  - Your request for review;
  - Your dental plan;
  - evidence of coverage or similar document;
  - all medical records and supporting documentation used to render Our decision;
  - a summary of the applicable issues including a statement of Our decision;
  - the criteria used and any clinical reasons for Our decision; and
  - the relevant portions of Our utilization review guidelines.

Within two (2) business days of receiving this information, the Director must determine if the service or claim is covered, issue a decision, and send a notice to Us, You, and Your treating provider.

Referral to the IRO for contract coverage cases: The Director is sometimes unable to determine issues of coverage. If this occurs, the Director will forward Your case to an external IRO. The IRO will have 72 hours to make a decision and send it to the Director. The Director will have one (1) business day after receiving the IRO's decision to send the decision to Us, You and Your treating provider.

The decision (contract coverage): If You disagree with the Director's final decision on a contract coverage issue, You may request a hearing with the Office of Administrative Hearings ("OAH"). If We disagree with the Director's final decision, We may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision. **The** OAH must promptly schedule and complete a hearing for appeals from expedited Level 3 decisions.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Level 1: Informal Reconsideration

Your Request: **You may obtain an Informal Reconsideration of Your denied request for a service if:**

- You have coverage with Us;
- We denied Your request for a covered service or claim;
- You do not qualify for an expedited appeal; and
- You or Your treating provider asks for Informal Reconsideration within two (2) years of the date We first deny the requested service by calling, writing, or faxing Your request to:

Quality Management Department
P.O. Box 1860
Alpharetta, GA 30023
800-422-4234Fax: 770-641-5389

Claim for a covered service already provided but not paid for: You may not obtain an Informal Reconsideration of Your denied request for the payment of a covered service. Instead, You may start the review process by seeking a Formal Appeal (Level 2).

Our acknowledgement: We have five (5) business days after We receive Your request for an Informal Reconsideration ("the receipt date") to send You and Your treating provider a notice that We received Your request.

Our decision: We have 30 days after the receipt date to decide whether We should change Our decision and authorize Your requested service or pay Your claim. Within that same 30 days, We must send You and Your treating provider our written decision. The written decision must explain the reasons for Our decision and tell You the documents on which We based Our decision.

If We deny Your request: You have 60 days to appeal to Level 2.

If We grant Your request: We will authorize the service or pay the claim and the appeal is over.

If We refer Your case to Level 3: We may decide to skip Level 1 and Level 2 and send Your case straight to an independent reviewer at Level 3.

Level 2: Formal Appeal

Your request: You may request a Formal Appeal if: (1) We deny Your request at Level 1, or (2) You have an unpaid claim and We did not provide a Level 1 review. After You receive Our Level 1 denial, You or Your treating provider must send Us a written request within 60 days to tell us You are appealing to Level 2. If We did not provide a

Level 1 review of Your denied claim, You have two (2) years from Our first denial notice to request Formal Appeal. To help Us make a decision on Your appeal, You or Your provider should also send Us any information (that You haven't already sent Us) to show why We should authorize the requested service or pay the claim. Send Your appeal request and information to:

Quality Management Department
P.O. Box 1860
Alpharetta, GA 30023
800-422-4234
Fax: 770-641-5389

Our acknowledgement: We have five (5) business days after We receive Your request for Formal Appeal ("the receipt date") to send You and Your treating provider a notice that We received Your request.

Our decision: For a denied service that You have not yet received, We have 30 days after the receipt date to decide whether We should change Our decision and authorize Your requested service. For denied claims, We have 60 days to decide whether We should change Our decision and pay Your claim. We will send You and Your treating provider Our decision in writing. The written decision must explain the reasons for Our decision and tell You the documents on which We based Our decision.

If We deny Your request or claim: You have four (4) months to appeal to Level 3, External, Independent Review.

If We grant Your request: We will authorize the service or pay the claim and the appeal is over.

If We refer Your case to Level 3: We may decide to skip Level 2 and send Your case straight to an independent reviewer at Level 3.

Level 3: External, Independent Review

Your request: You may appeal to Level 3 only after You have appealed through Levels 1 and 2. You have four (4) months after You receive Our Level 2 decision to send Us Your written request for an External, Independent Review. Send Your request and any supporting information to:

Quality Management Department
P.O. Box 1860
Alpharetta, GA 30023
800-422-4234, Fax 770-641-5389

Neither You nor Your treating provider will be responsible for the cost of any External, Independent Review.

The process: There are two types of Level 3 appeals, depending on the issues in Your case:

(1) Medical Necessity: These are cases where We have decided not to authorize a service because We think the services You (or Your treating provider) are asking for, are not medically necessary to treat Your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside IRO, procured by the Department, and not connected with Us. For medical necessity cases, the independent reviewer must be a provider who typically manages the condition under review.

(2) Contract Coverage: These are cases where We have denied coverage because We believe the requested service is not covered under Your dental plan. For contract coverage cases, the Department is the independent reviewer.

Medical Necessity Cases

Within five (5) business days of receiving Your request, We must:

- Mail a written acknowledgement of the request to the Director, You, and Your treating provider; and
- Send the Director:
  - Your request for review;
  - Your dental plan contract;
  - evidence of coverage or similar document;
  - all medical (dental) records and supporting documentation used to render Our decision;
  - a summary of the applicable issues including a statement of Our decision;
  - the criteria used and clinical reasons for Our decision; and
  - the relevant portions of Our utilization review guidelines.

We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within five (5) days of receiving Our information, the Director must send all the submitted information to an external IRO.

Within 21 days of receiving the information, the IRO must make a decision and send the decision to the Director.

Within five (5) business days of receiving the IRO's decision, the Director must mail a notice of the decision to Us, You, and Your treating provider.

The decision (medical necessity): If the IRO decides that We should provide the service or pay the claim, We must authorize the service or pay the claim. If the IRO agrees with Our decision to deny the service or payment, the appeal is over. Your only further option is to pursue Your claim in court.

Contract Coverage Cases

Within five (5) business days of receiving Your request, We must:

- Mail a written acknowledgement of Your request to the Director, You, and Your treating provider; and
- Send the Director:
  - Your request for review;
  - Your dental plan contract;
  - evidence of coverage or similar document;
  - all medical records and supporting documentation used to render Our decision;
  - a summary of the applicable issues including a statement of Our decision;
  - the criteria used and any clinical reasons for Our decision; and
  - the relevant portions of Our utilization review guidelines.

Within 15 business days of receiving this information, the Director must determine if the service or claim is covered, issue a decision, and send a notice to Us, You, and Your treating provider. If the Director decides that We should provide the service or pay the claim, We must do so.

Referral to the IRO for contract coverage cases: The Director is sometimes unable to determine issues of coverage. If this occurs, the Director will forward Your case to an IRO. The IRO will have 21 days to make a decision and send it to the Director. The Director will have five (5) business days after receiving the IRO's decision to send the decision to Us, You, and Your treating provider.

The decision (contract coverage): If You disagree with the Director's final decision on a coverage issue, You may request a hearing with the Office of Administrative Hearings ("OAH"). If We disagree with the Director's determination of coverage issues, We may

also request a hearing at OAH. Hearings must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Obtaining Medical (Dental) Records

Arizona law permits You to ask for a copy of Your medical records. Your request must be in writing and must specify who You want to receive the records. The health care provider who has Your records will provide You or the person You specified with a copy of Your records.

Designated Decision-Maker: If You have a designated health care decision-maker, that person must send a written request for access to or copies of Your medical records. The medical records must be provided to Your health care decision-maker or a person designated in writing by Your health care decision- maker unless You limit access to Your medical records only to Yourself or Your health care decision-maker.

Confidentiality: Medical records remain confidential. If You participate in the appeal process, the relevant portions of Your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose Your medical information to any other people.

Documentation for an Appeal

If You decide to file an appeal, You must give Us any material justification or documentation for the appeal at the time the appeal is filed. If You gather new information during the course of Your appeal, You should give it to Us as soon as You receive it. You must also give Us the address and phone number where You can be contacted. If the appeal is already at Level 3, You should also send the information to the Department.

The Role of the Director of Insurance ("Director")

Arizona law requires "any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for appealable decisions, You must pursue the health care appeals process before the Director can investigate a complaint You may have against Our company based on the decision at issue in the appeal.

The appeal process requires the Director to:

- Oversee the appeals process.
- Maintain copies of each utilization review plan submitted by insurers.
- Receive, process, and act on requests from an insurer for External Independent Review.
- Enforce the decisions of insurers.
- Review decisions of insurers.
- Report to the Legislature.
- Send, when necessary, a record of the proceedings of an appeal to the court or to the Office of Administrative Hearings (OAH).
- Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at OAH.

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means Your last known address.

HEALTH CARE APPEAL REQUEST FORM

You may use this form to tell Your insurer You want to appeal a denial decision.
Quality Management Department, P.O. Box 1860, Alpharetta, GA 30023
800-422-4234, Fax 770-641-5389

Your Name_____Your ID # _____

Name of representative pursuing appeal, if different from above

_____

Mailing Address_____Phone # _____

City_____State_____Zip Code _____

Type of Denial: □ Denied Claim □ Denied Service Not Yet Received

Name of Insurer that denied the claim/service: _____

If You are appealing Your insurer's decision to deny a service You have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in Your health?

If Your answer is "Yes," You may be entitled to an expedited appeal. Your treating provider must sign and send certification and documentation supporting the need for an expedited appeal. What decision are You appealing?

_____
_____
_____
_____

(Explain what You want Your insurer to authorize or pay for.)

Explain why You believe the claim or service should be covered:_____
_____
_____
_____
_____

(Attach additional sheets of paper, if needed.)

If You have questions about the appeals process or need help to prepare Your appeal, You may call the Department of Insurance Consumer Assistance number 602-364-2499 or 800-325-2548 (toll free in Arizona - outside the Phoenix metro area), or Us at 800-422-4234.

Make sure to attach everything that shows why You believe Your insurer should cover Your claim or authorize a service, including:

□Medical records□Supporting documentation (letter from Your doctor, brochures, notes, receipts, etc.) **Also attach the certification from Your treating provider if You are seeking expedited review.

_____

Your Signature or authorized representative Date

PROVIDER CERTIFICATION FORM FOR EXPEDITED MEDICAL REVIEWS

(You and Your provider may use this form when requesting an expedited appeal.)
Quality Management Department, P.O. Box 1860, Alpharetta, GA 30023
800-422-4234, Fax 770-641-5389

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 60 days) "is likely to cause a significant negative change in the patient's medical condition at issue."

PROVIDER INFORMATION

Treating Physician/Provider_____
Phone #_____FAX # _____
Address_____
City_____State_____Zip Code _____

PATIENT INFORMATION

Patient's Name_____Member ID # _____
Phone #_____FAX # _____
Address_____
City_____State_____Zip Code _____

INSURER INFORMATION

Insurer Name_____
Phone #_____FAX # _____
Address_____
City_____State_____Zip Code _____

Is the appeal for a service that the patient has already received? □Yes □No

If "Yes," the patient must pursue the standard appeals process and cannot use the expedited appeals process.

If "No," continue with this form.

□ What service denial is the patient appealing? _____

_____

_____

_____

□ Explain why You believe the patient needs the requested service and why the time for the standard appeal process will harm the patient. _____

_____

_____

Attach additional sheets if needed, and include: □ Medical records □Supporting documentation

If You have questions about the appeals process or need help regarding this certification, You may call the Department of Insurance Consumer Assistance number 602-364-2499 or 800-325-2548. You may also call Us at 800-422-4234.

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the informal reconsideration and formal appeal processes (about 60 days) is likely to cause a significant negative change in the patient's medical condition at issue.

Provider's Signature_____Date _____

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

Toll Free
800-422-4234

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023

800-422-4234