DeltaCare® USA

Dental Health Care Plan

Evidence of Coverage

Underwritten by:

Alpha Dental of Nevada, Inc.
(A Nevada Corporation)
5920 S. Rainbow Blvd. Suite 10
Las Vegas, NV 89118

Administered by:

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

deltadentalins.com

EVIDENCE OF COVERAGE DISCLOSURE FORM

DeltaCare USA Dental Health Care Program

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 Nevada, Inc. ("Company"), on behalf of itself, and its affiliated companies. To offer these benefits, the Contractholder has entered into a Group Dental Service Contract with Us.

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

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 will be mailed to each new Enrollee and 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 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.

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.

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.

Contract Orthodontist: A Dentist who specializes in orthodontics and who has agreed to provide Benefits under this Plan.

Contract Specialist: A Dentist who provides Specialist Services and who has agreed to provide Benefits under this Plan.

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.

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 the Enrollee is 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:

1) The Spouse
- unmarried dependent children from birth to age 19, or to age 26 if enrolled as full-time students in an accredited school, college or university

Children include natural children, stepchildren, foster children, 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 begins or coverage begins.

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

Enrollee ("Primary Enrollee"): An eligible Employee or an eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Grace Period: A period of no less than thirty (30) 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 Year.

Optional Treatment: Any alternative procedure presented by the Contract Dentist 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 the terms of this Plan. Also referred to as Non-participating Dentist.

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

Premium: Payment made in consideration of dental coverage under the Contract.

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

Special Enrollment Period: The period of time outside Your Open Enrollment Period during which individuals eligible as Primary Enrollees or Dependents who experience certain qualifying events may enroll in this Plan.

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 authorized by Us.

Spouse: An individual who is a partner of the Primary Enrollee as:
1) 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;
2) Defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides; or
3) May be recognized by the Contractholder.

Eligibility for Benefits

The Contractholder is responsible for establishing eligibility and reporting enrollment to Us. We process enrollment as reported by the Contractholder. You will receive Benefits as soon as You are enrolled in the Plan.

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

Dependents include:
1) Your Spouse;
2) Dependent children, including: natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as recognized by the Contractholder,

as required by a court or administrative order and subject to the following terms:

- Dependent children other than grandchildren from birth to age 26 regardless of marital status.
- Adopted children are eligible from the time You are a party in an adoption suit for such children.
- Newborn and adopted children will automatically be covered 31 days after birth or adoption. For coverage to continue after the 31-day period, verbal or written notice of birth or notice regarding the adoption suit and any additional Premiums, if any, must be received within the 31-day period.

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 under the Contract as a Primary Enrollee or as a Dependent Enrollee but not both at the same time.

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.

Medicare eligibility will not affect Your eligibility or your Dependent's eligibility.

Overage Children

An overage 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 the Primary Enrollee for support; and
3) Proof of disability is provided within 31 days of request. 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 reached 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,
1) You must enroll within 31 days after the date You become eligible or during an Open Enrollment Period.
2) All Dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period or Special Enrollment Period.
3) If You elect Dependent coverage, You must enroll all of Your Dependent Enrollees for coverage.
4) You:
    a) Must pay Premiums in the manner elected by the Contractholder and approved by Us, and
    b) 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.

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:
1) Marital status (marriage, divorce, legal separation, annulment or death);
2) 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);
3) Dependent child ceases to satisfy eligibility requirements;
4) Residence (You move);
5) Court order requiring dependent coverage;
6) Any other current or future election changes permitted by Internal Revenue Code Section 125; or
7) Any other changes specified by applicable law or regulation.

Premiums
This plan requires Premiums to be paid to Us. If You are required to pay all or any portion of the Premiums, You will be advised of the amount prior to enrollment and it will be paid directly to the Contractholder or You will be requested to pay it directly.

The Contractholder will be responsible for sending all payments of Premiums to Us except payments You are requested to pay directly.

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

We will provide Your Plan with Contract Dentists at convenient locations. To enroll, You must select a Contract Dentist from the list of Dentists provided at deltadentalins.com. You and Your Dependent Enrollees may collectively select no more than three (3) Contract Dentists. 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 to Your assigned Contract Dentist by contacting the Customer Service at 800-422-4234. Requests to change Your Contract Dentist must be made prior to the 21st of the month to become 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:

1) Is no longer taking further enrollment;
2) No longer participates in the Plan; or
3) 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:

1) Partial or full dentures for which final impressions have been taken;
2) 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).

Services for Benefits must be provided by the Contract Dentist assigned to You or Your Dependents or a Contract Specialist upon referral by the Contract Dentist and authorized by Us. 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.

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:

1) A partial or full denture for which final impressions have been taken; or
2) 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.

Dental treatment in progress must be completed under this Plan in which treatment was started. No Plan changes may be made while dental treatment is in progress

Copayments and Other Charges

In order to keep Your Plan affordable, this Plan includes certain cost-sharing features. First, not all dental services or procedures may be included under Your Plan. If the procedure is not listed in the *Schedules*, it is not covered. You will be responsible to pay the Dentist the full charge for any service not included in Your Plan.

Certain procedures require You to pay a Copayment. Copayments are listed in the *Schedules* and must be paid directly to the treating Dentist. Any charges for broken appointments and visits after normal visiting hours, if covered, are also listed in the *Schedules*.

Should We fail to pay a Contract Dentist, You will not be liable to that Dentist for any sums owed by Us. If You have not received Authorization for treatment from an Out-of-Network Dentist, and We fail to pay that Out-of-Network Dentist, You may be liable to

that Dentist for the cost of services. For further clarification, see *"Emergency Services"*.

Emergency 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, You should call 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:
1) During non-business hours, or
2) If You require Emergency Services and are thirty-five (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 the 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, periodontics or pediatric dentistry must be:
- Referred by Your Contract Dentist
2) Authorized by Us.

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

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

Claims for Reimbursement
Claims for covered Emergency Services or authorized Specialist Services should be submitted for payment within ninety (90) days of

receiving treatment. Claims must be received within one (1) year of the treatment date. The address for claims submission is:

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

Coordination of Benefits
If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, Benefits will be coordinated. If this plan is the "primary" plan, We will not reduce Benefits.

If this plan is the "secondary" plan, We may reduce Benefits so that the total benefits paid or provided by all plans do not exceed 100% of total allowable expense.

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

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

(1) The plan covering You as an employee or Primary Enrollee is primary over a plan covering You as a dependent.

- The plan covering You as an employee is primary over a plan covering You as a dependent; except that if You are also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
  - Secondary to the plan covering You as a dependent; and
  - Primary to the plan covering You as other than a dependent (e.g. a retired employee), then the Benefits of the plan covering You as a dependent are determined before those of the plan covering You as other than a dependent.

(3) Except as stated in paragraph (4), when this plan and another plan cover the same child as a dependent of different persons, referred to as parents:

a) The Benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

b) If both parents have the same birthday, the Benefits of the plan covering one parent longer are determined before those of the plan covering the other parent for a shorter period of time.

c) However, if the other plan has no birthday rule, but has a rule based on the gender of the parent, and as a result, the plans do not agree on the order of Benefits, the rule in the other plan determines the order of Benefits.

(4) In the case of a dependent child of legally separated or divorced parents, the plan covering the child as a dependent of the parent with legal custody or as a dependent of the custodial parent's spouse (i.e. step-parent) will be primary over the plan covering the child as a dependent of the parent without legal custody.

If there is a court decree establishing financial responsibility for the child's health care expenses, the Benefits of a plan covering the child as a dependent of the parent with financial responsibility will be determined before the Benefits of any other policy covering the child as a dependent child.

(5) If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the child's health care expenses, the plans covering the child will follow the order of benefit determination rules outlined in paragraph (3).

(6) The benefits of a plan covering You as an employee who is neither laid-off nor retired are determined before those of a plan covering You as a laid-off or retired employee. The same holds true if You are a dependent of a Primary Enrollee as a retiree or an employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule (6) is ignored.

(7) If Your coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination.

a) First, the benefits of a plan covering the Enrollee as an employee or Primary Enrollee (or the Primary Enrollee's dependent).

b) Second, the benefits under the continuation coverage.

c) If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule (7) is ignored.

(8) If none of the above rules determines the order of benefits, the benefits of the plan covering an employee longer are determined before those of the plan covering that insured person for the shorter term.

(9) When determination cannot be made in accordance with the rules above, the benefits of a plan that is a medical plan covering dental as a benefit will be primary to a standalone dental plan. The standalone dental plan is primary when the dental benefit is provided by an oral and maxillofacial surgeon.

Enrollee Complaint Procedure

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

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

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

1) Patient's name
2) Primary Enrollee's name, address, telephone number and identification number
3) Contractholder's name
4) Treating Dentist's name and location.

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

Upon request and free of charge, You will be provided with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination.

If the review of a denial is based, in whole or in part, on a lack of medical (dental) 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 made available upon request.

Within ten (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 thirty (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 thirty (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 thirty (30) days after receipt of Your appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If We require You to be examined by a dental consultant for any reason, it will only be conducted by a Contracted Dentist. If You disagree with the findings of the evaluation, then the dispute will be resolved through binding arbitration. The arbitration must be conducted pursuant to the rules for commercial arbitration established by the American Arbitration Association. We are responsible for any administrative fees and expenses relating to the arbitration, except that We are not responsible for attorney's fees and fees for expert witnesses unless those fees are awarded by the arbitrator. If a dispute required to be submitted to binding arbitration requires immediate resolution to protect Your physical health, any party to the dispute may waive arbitration and seek declaratory relief in a court of competent jurisdiction.

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 US Department of Labor may be contacted at:

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

If You believe You need further review of Your claim, You may contact the Nevada Division of Insurance and pursue the following procedure:

In accordance with Nevada law, the Division of Insurance has established a procedure to assist You in making any additional inquiry or complaint concerning coverage under this EOC. You may contact the Division of Insurance by telephone as follows:

Name of Division: The Department of Business and Industry, Division of Insurance

Telephone Numbers:

If You have local access to the Carson City Office of the Division, You may call (775) 687-0700.

If You have local access to the Las Vegas Office of the Division, You may call (702) 486-4009.

If You do not have local access to either of those Offices, You may call (888) 872-3234.

Hours of Operation: Monday through Friday from 8 a.m. until 5 p.m. Pacific Standard Time (PST).

Renewal and Termination of Benefits
This Plan renews on the anniversary of the Contract unless We provide sixty (60) days advance written notice of a change in Premiums or Benefits and the Contractholder does not accept the change. Your Benefits will terminate:

1) As of the date that this Plan is terminated,
2) You or your Dependents cease to be eligible under the terms of this Plan, or
3) You or Your Dependents 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 *Continuation of Coverage under USERRA* provision, Your enrollment 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 fifteen (15) days written notice if the Premiums are not paid by, or on behalf of You, on the date due. However, You may continue to receive Benefits during the fifteen (15) day period and may be reinstated during the term of the Contract upon payment of any unpaid Premium.
3) Upon 30 days written notice if:
   a) The Contract is terminated or not renewed;
   - You knowingly commit or permit another person to commit fraud or deception in obtaining Benefits under this Plan;
   c) You fail to pay Copayments. However, You may be reinstated during the term of the Contract upon payment of all delinquent charges; or

d) A satisfactory dentist-patient relationship fails to be established with multiple Contract Dentists. We must show that We have, in good faith, provided You with an opportunity to select an alternative Contract Dentist. If You establish a history of unsatisfactory relationships, We will notify You in writing, at least thirty (30) days in advance, that We consider the dentist-patient relationship 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 fifteen (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

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

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

Incontestability
After this Contract has been in force for three (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 three (3) years or more during the Your lifetime.

No claims for loss incurred or disability commencing after 3 years from the date of issue of the Contract will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed prior to the Effective Date of this Contract.

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

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

Processing Policies
Our DeltaCare USA dental care guidelines explain the services are covered under the Plan. Contract Dentists use professional judgment to determine appropriate services for You. Benefits performed by Contract Dentists are provided subject to any Copayments. If a Contract Dentist believes that You should seek treatment from a specialist, the Contract Dentist contacts Us for a determination of whether the proposed treatment is a covered benefit. We will determine whether the proposed treatment requires treatment by a specialist. 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:
1) Twenty-four (24) months, beginning on the date the leave of absence begins, or;
2) The date You fail to return to work within the time required by USERRA.

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. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We:
1) Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    a) Qualified sign language interpreter

b) Written information in other formats (large print, audio, accessible electronic formats, other formats)

2) Provide free language services to people whose primary language is not English, such as:
   a) Qualified interpreters
   b) Information written in other languages

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

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

DeltaCare USA
18000 Studebaker Road, Suite 530
Cerritos, CA 90703
Telephone Number: 800-471-9925
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 attending Contract Dentist subject to the limitations and exclusions of the plan. Please refer to the *DeltaCare USA Limitations and Exclusions* section for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

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

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0210	Intraoral - comprehensive series of radiographic images - *limited to one series every 24 months*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
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 one series every six months*	No Cost
D0330	Panoramic radiographic image - *limited to 1 every 24 months*	No Cost
D0350	2D oral/facial photographic images obtained intraorally or extraorally	No Cost
D0396	3D printing of a 3D dental surface scan	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0460	Pulp vitality tests	No Cost
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

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *2 D1110, D1120 or D4346 per 12 month period*	No Cost
D1120	Prophylaxis *cleaning* - child - *2 D1110, D1120 or D4346 per 12 month period*	No Cost
D1206	Topical application of fluoride varnish - *child to age 19; 2 D1206 or D1208 per 12 month period*	No Cost

D1208	Topical application of fluoride - excluding varnish - *child to age 19; 2 D1206 or D1208 per 12 month period*	No Cost
D1330	Oral hygiene instructions	No Cost
D1354	Application of caries arresting medicament - per tooth - *child to age 19; 2 per 12 month period*	No Cost
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No Cost
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No Cost
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No Cost

D2000-D2999 III. RESTORATIVE

- Base metal is the Benefit. Noble or high noble metal (semi-precious, precious), if used, will be charged to the Enrollee at the additional maximum cost to the Enrollee of $300.00 for noble metal and $350.00 for high noble metal (including titanium) per tooth. If an indirectly fabricated post and core is made of high noble metal, an additional fee up to $100.00 per tooth will be charged for the upgraded post and core.

- $75.00 fee per crown unit above the co-pay for porcelain on molars.

- 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 requires the existing restoration to be 5+ years old.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2740	Crown - porcelain/ceramic	$40.00

D2750	Crown - porcelain fused to high noble metal	$50.00
D2751	Crown - porcelain fused to predominantly base metal	$50.00
D2752	Crown - porcelain fused to noble metal	$50.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$50.00
D2780	Crown - 3/4 cast high noble metal	$50.00
D2781	Crown - 3/4 cast predominantly base metal	$50.00
D2782	Crown - 3/4 cast noble metal	$50.00
D2790	Crown - full cast high noble metal	$50.00
D2791	Crown - full cast predominantly base metal	$50.00
D2792	Crown - full cast noble metal	$50.00
D2794	Crown - titanium and titanium alloys	$50.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	No Cost
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2940	Protective restoration	No Cost
D2949	Restorative foundation for an indirect restoration	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *base metal post; includes canal preparation*	No Cost
D2954	Prefabricated post and core in addition to crown - *includes canal preparation*	No Cost
D2976	Band stabilization - per tooth - *limited to once in a lifetime per tooth*	No Cost
D2989	Excavation of a tooth resulting in the determination of non-restorability	No Cost

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$20.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$20.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$20.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$10.00
D3346	Retreatment of previous root canal therapy - anterior	$20.00
D3347	Retreatment of previous root canal therapy - premolar	$20.00
D3348	Retreatment of previous root canal therapy - molar	$20.00
D3410	Apicoectomy - anterior	$10.00
D3421	Apicoectomy - premolar (first root)	$10.00
D3425	Apicoectomy - molar (first root)	$10.00
D3426	Apicoectomy (each additional root)	$10.00
D3430	Retrograde filling - per root	$10.00
D3471	Surgical repair of root resorption - anterior	$10.00
D3472	Surgical repair of root resorption - premolar	$10.00
D3473	Surgical repair of root resorption - molar	$10.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$10.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$10.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar ...	$10.00

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	$25.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$19.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$25.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$19.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$25.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$19.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *2 D1110, D1120 or D4346 per 12 month period*	No Cost
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	No Cost
D4910	*Additional periodontal maintenance (within the 6 month period)*	No Cost
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 up to three after delivery adjustments, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the

service must be provided at the Contract Dentist's facility where the denture was originally delivered.
- Relines are limited to 2 per denture during any 12 consecutive months.
- Replacement of a denture or a partial denture requires the existing denture to be 3+ years old.

D5110	Complete denture - maxillary	$50.00
D5120	Complete denture - mandibular	$50.00
D5130	Immediate denture - maxillary	$50.00
D5140	Immediate denture - mandibular	$50.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$60.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$60.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$60.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$60.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$60.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$60.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$60.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$60.00
D5410	Adjust complete denture - maxillary	No Cost
D5411	Adjust complete denture - mandibular	No Cost
D5421	Adjust partial denture - maxillary	No Cost
D5422	Adjust partial denture - mandibular	No Cost
D5511	Repair broken complete denture base, mandibular	No Cost
D5512	Repair broken complete denture base, maxillary	No Cost
D5611	Repair resin partial denture base, mandibular	No Cost
D5612	Repair resin partial denture base, maxillary	No Cost
D5640	Replace broken teeth - per tooth	No Cost

D5650	Add tooth to existing partial denture	$50.00
D5710	Rebase complete maxillary denture	$50.00
D5711	Rebase complete mandibular denture	$50.00
D5720	Rebase maxillary partial denture	$60.00
D5721	Rebase mandibular partial denture	$60.00
D5725	Rebase hybrid prosthesis	$60.00
D5730	Reline complete maxillary denture (chairside)	$15.00
D5731	Reline complete mandibular denture (chairside)	$15.00
D5740	Reline maxillary partial denture (chairside)	$15.00
D5741	Reline mandibular partial denture (chairside)	$15.00
D5750	Reline complete maxillary denture (laboratory)	$15.00
D5751	Reline complete mandibular denture (laboratory) ..	$15.00
D5760	Reline maxillary partial denture (laboratory)	$15.00
D5761	Reline mandibular partial denture (laboratory)	$15.00
D5765	Soft liner for complete or partial removable denture - indirect	$15.00

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])

- Base metal is the Benefit. Noble or high noble metal (semi-precious, precious), if used, will be charged to the Enrollee at the additional maximum cost to the Enrollee of $300.00 for noble metal and $350.00 for high noble metal (including titanium) per tooth.
- $75.00 fee per crown or pontic unit above the co-pay for porcelain on molars.
- 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	$50.00
D6211	Pontic - cast predominantly base metal	$50.00
D6212	Pontic - cast noble metal	$50.00
D6214	Pontic - titanium and titanium alloys	$50.00
D6240	Pontic - porcelain fused to high noble metal	$75.00

D6241	Pontic - porcelain fused to predominantly base metal	$75.00
D6242	Pontic - porcelain fused to noble metal	$75.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$75.00
D6250	Pontic - resin with high noble metal	$50.00
D6251	Pontic - resin with predominantly base metal	$50.00
D6252	Pontic - resin with noble metal	$50.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$35.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$35.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$35.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$35.00
D6606	Retainer inlay - cast noble metal, two surfaces	$35.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$35.00
D6624	Retainer inlay - titanium	$35.00
D6720	Retainer crown - resin with high noble metal	$50.00
D6721	Retainer crown - resin with predominantly base metal	$50.00
D6722	Retainer crown - resin with noble metal	$50.00
D6750	Retainer crown - porcelain fused to high noble metal	$75.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$75.00
D6752	Retainer crown - porcelain fused to noble metal	$75.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$75.00
D6780	Retainer crown - 3/4 cast high noble metal	$40.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$40.00
D6782	Retainer crown - 3/4 cast noble metal	$40.00
D6784	Retainer crown - 3/4 titanium and titanium alloys	$40.00
D6790	Retainer crown - full cast high noble metal	$40.00
D6791	Retainer crown - full cast predominantly base metal	$40.00

D6792	Retainer crown - full cast noble metal	$40.00
D6794	Retainer crown - titanium and titanium alloys	$50.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No Cost
D7220	Removal of impacted tooth - soft tissue	$15.00
D7230	Removal of impacted tooth - partially bony	$15.00
D7240	Removal of impacted tooth - completely bony	$15.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7284	Excisional biopsy of minor salivary glands - *does not include pathology laboratory procedures*	No Cost
D7285	Incisional biopsy of oral tissue-hard (bone, tooth) ..	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost
D7963	Frenuloplasty	No Cost

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 $25.00, 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:	No Cost
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	No Cost
D0802	3D dental surface scan - indirect	No Cost
D0803	3D facial surface scan - direct	No Cost
D0804	3D facial surface scan - indirect	No Cost

	The Benefit for post-treatment records includes:	No Cost
D0210	Intraoral - comprehensive series of radiographic images	
D0470	Diagnostic casts	

D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,000.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,350.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$250.00

D8681	Removable orthodontic retainer adjustment	No Cost
D8698	Re-cement or re-bond fixed retainer - maxillary	No Cost
D8699	Re-cement or re-bond fixed retainer - mandibular	No Cost
D8701	Repair of fixed retainer, includes reattachment - maxillary	No Cost
D8702	Repair of fixed retainer, includes reattachment - mandibular	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$200.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9120	Fixed partial denture sectioning	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with a medical health care professional	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled 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 the Contract Dentist, You pay the specified Copayment. Listed procedures which require a Dentist to provide Specialized Services, and are referred by the Contract Dentist, must be authorized by Us. You pay the Copayment specified for such services.

SCHEDULE B

Limitations and Exclusions of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in the *Description of Benefits and Copayments. (Frequency limitations on diagnostic and preventive procedures do not apply when services are needed more frequently due to medical necessity as determined by the Contract Dentist.*
2. If the Enrollee accepts a treatment plan from the general Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. Benefits provided by a pediatric Dentist are limited to children through age 13 following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Us, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
4. The cost to an Enrollee receiving orthodontic treatment whose coverage is canceled or terminated for any reason will be based on a maximum Copayment of $1,750.00, excluding any charges for diagnostic records, for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
5. 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 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.

Exclusions of Benefits

1. Any procedure that is not specifically listed under the *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, 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) for children under 16 years of age.
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. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered Benefits.
10. 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.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's 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.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedure D9944, D9945, D9946 (occlusal guards).
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed Dentist. Self-administered Orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

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.

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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)

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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)

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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)

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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 אַנדער 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)

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