

# 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](http://deltadentalins.com)

# **EVIDENCE OF COVERAGE DISCLOSURE FORM**

## **DeltaCare USA Dental Health Care Program**

### **DeltaCare<sup>®</sup> 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](http://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](http://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:** An eligible Employee ("Primary Enrollee") 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:

- *Schedule A, Description of Benefits and Copayments*, and
- *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:

- 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 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:

- 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:

- 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;
- The child is chiefly dependent on the Primary Enrollee for support; and
- 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,

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

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.

## **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 (marriage, divorce, legal separation, annulment or death);
- Number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- Dependent child ceases to satisfy eligibility requirements;
- Residence (You move);
- Court order requiring dependent 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**

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](http://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 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:

- Is no longer taking further enrollment;
- No longer participates in the Plan; or
- 3) Requests, for good cause, that You or Your Dependents be reassigned 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).

Services for Benefits must be provided by Your Contract Dentist. Specialist Services, obtained from a Contract Orthodontist or Contract Specialist (not including pediatric Dentists), must be referred by Your Contract Dentist. We have no obligation or liability with respect to services provided by Out-of-Network Dentists, except for 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:

- 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.

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 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:

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

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim), You must file a request for review, referred to as a complaint, with Us within 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 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.

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:

- As of the date that this Plan is terminated,
- You or your Dependents cease to be eligible under the terms of this Plan, or
- 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:

Immediately:

- Upon loss of eligibility as described in this EOC; or
- If You engage in conduct detrimental to safe operations and the delivery of services while receiving services from a Contract Dentist.

- 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.

Upon 30 days written notice if:

- 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;
- You fail to pay Copayments. However, You may be reinstated during the term of the Contract upon payment of all delinquent charges; or

- 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:

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

- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If You need these services, 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](http://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-2025 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.**

| <u>CODE</u>        | <u>DESCRIPTION</u>   | <u>ENROLLEE PAYS</u> |
|--------------------|--|----------------------|
| <b>D0100-D0999</b> | <b>I. DIAGNOSTIC</b>   |                      |
| 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 - <i>limited to one series every 24 months</i> ..... | No Cost              |
| D0220              | Intraoral - periapical first radiographic image .....  | No Cost              |
| D0230              | Intraoral - periapical each additional radiographic image .....  | No Cost              |
| D0240              | Intraoral - occlusal radiographic image .....  | No Cost              |
| D0250              | Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector ..... | No Cost              |
| D0251              | Extraoral posterior dental radiographic image .....  | No Cost              |
| D0270              | Bitewing - single radiographic image .....   | No Cost              |

|       |   |         |
|-------|---|---------|
| D0272 | Bitewings - two radiographic images .....   | No Cost |
| D0273 | Bitewings three radiographic images .....   | No Cost |
| D0274 | Bitewings - four radiographic images - <i>limited to one series every six months</i> .....          | No Cost |
| D0330 | Panoramic radiographic image - <i>limited to 1 every 24 months</i> .....                            | No Cost |
| D0350 | 2D oral/facial photographic images obtained intra-orally or extra-orally .....                      | No Cost |
| D0396 | 3D printing of a 3D dental surface scan .....   | No Cost |
| D0419 | Assessment of salivary flow by measurement - <i>1 every 12 months</i> .....                         | No Cost |
| D0460 | Pulp vitality tests .....   | No Cost |
| 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 <i>cleaning</i> - adult - <i>2 D1110, D1120 or D4346 per 12 month period</i> .....               | No Cost |
| D1120 | Prophylaxis <i>cleaning</i> - child - <i>2 D1110, D1120 or D4346 per 12 month period</i> .....               | No Cost |
| D1206 | Topical application of fluoride varnish - <i>child to age 19; 2 D1206 or D1208 per 12 month period</i> ..... | No Cost |

|       |  |         |
|-------|--|---------|
| D1208 | Topical application of fluoride - excluding varnish<br>- 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 ( <i>anterior</i> ) .....                                       | 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 | Placement of interim direct 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 - <i>base metal post; includes canal preparation</i> ..... | No Cost |
| D2954 | Prefabricated post and core in addition to crown - <i>includes canal preparation</i> .....                           | No Cost |
| D2956 | Removal of an indirect restoration on a natural tooth .....  | No Cost |
| D2976 | Band stabilization - per tooth - <i>limited to once in a lifetime per tooth</i> .....                                | 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 dentino cemental junction and application of medicament ..... | No Cost |
| D3310 | <i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration) .....   | \$20.00 |
| D3320 | <i>Root canal</i> - endodontic therapy, premolar tooth (excluding final restoration) .....   | \$20.00 |
| D3330 | <i>Root canal</i> - 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 - <i>limited to 4 quadrants during any 12 consecutive months</i> .....                              | No Cost |
| D4342 | Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i> .....                              | No Cost |
| D4346 | Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>2 D1110, D1120 or D4346 per 12 month period</i> ..... | No Cost |
| D4910 | Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i> .....  | No Cost |
| D4910 | <i>Additional periodontal maintenance (within the 6 month period)</i> .....  | 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 missing or broken teeth - partial denture - per tooth .....   | No Cost |
| D5650 | Add tooth to existing partial denture - per tooth ....                | \$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 |
| D7252 | Partial extraction for immediate implant placement - <i>Once in a lifetime</i> .....  | No Cost |
| D7284 | Excisional biopsy of minor salivary glands - <i>does not include pathology laboratory procedures</i> .....  | No Cost |
| D7285 | Incisional biopsy of oral tissue-hard (bone, tooth) ..  | No Cost |
| D7286 | Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i> .....   | 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 - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*

D0322 Tomographic survey

D0330 Panoramic radiographic image - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*

D0340 2D cephalometric radiographic image - acquisition, measurement and analysis

D0350 2D oral/facial photographic images obtained intra-orally or extra-orally

D0396 3D printing of a 3D dental surface scan

D0470 Diagnostic casts

D0801 3D intraoral 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 - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*

D0470 Diagnostic casts

|       |   |            |
|-------|---|------------|
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> .....                             | \$1,000.00 |
| D8090 | Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> .....    | \$1,350.00 |
| D8091 | Comprehensive orthodontic treatment with orthognathic surgery - <i>adults, including covered dependent adult children</i> ..... | \$1,560.00 |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of <i>removable</i> 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 - <i>includes treatment planning session</i> .....                                 | \$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 - <i>without 24 hour notice - per 15 minutes of appointment time</i> .....        | \$10.00 |
| D9987 | Cancelled appointment - <i>without 24 hour notice - per 15 minutes of appointment time</i> .....     | \$10.00 |
| D9990 | Certified translation or sign-language services - per visit .....                                    | No Cost |
| D9991 | Dental case management - addressing appointment compliance barriers .....                            | No Cost |
| D9992 | Dental case management - care coordination .....   | No Cost |
| D9995 | Teledentistry - synchronous; real-time encounter ...   | No Cost |
| D9996 | Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review .... | No Cost |
| D9997 | Dental case management - Patients with special Health Care Needs .....                               | No Cost |

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 Specialist Services must be referred by the Contract Dentist. 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:
  - \* has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
  - \* is inconsistent with generally accepted standards for dentistry.
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 Contract 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.

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