



A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

Delta Dental Individual & Family™

Delta Dental PPO™
Basic Plan for Families

Combined Policy and Disclosure Form

Provided by:

Delta Dental Insurance Company
(a Delaware Corporation)

deltadentalins.com

HealthCare.gov
800-318-2596

Policy

You must make an election on the Federally Facilitated Marketplace for any eligible person You wish to cover under this Policy. If an election is not made on the Federally Facilitated Marketplace for an individual or dependent, such person will not be eligible under this Policy.

Your dental plan is underwritten and administered by Delta Dental Insurance Company (“Delta Dental”). We will pay Benefits for covered dental services as set forth in this Policy. This Policy is issued in exchange for payment of the first installment of Premium and on the basis of the statements made on Your application through the Federally Facilitated Marketplace. It takes effect on the Effective Date shown in the Policy Information attached to this Policy. This Policy will remain in force unless otherwise terminated in accordance with its terms, until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., local time, where You live.

READ YOUR POLICY AND ATTACHMENTS CAREFULLY

RIGHT TO EXAMINE AND RETURN THIS POLICY

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

Note: Persons eligible for Medicare have the right to return this Policy for any reason within thirty (30) days after its delivery and will have the premium refunded.

RENEWABLE - PREMIUM MAY CHANGE CONDITIONALLY:

The rate of the monthly Premiums will not be increased during the initial Policy Year.

The Responsible Party will receive renewal information from the Federally Facilitated Marketplace prior to any applicable open enrollment period. Provided We continue to make this policy available through the Federally Facilitated Marketplace at the renewal period:

- the Responsible Party may elect to choose this Contract on behalf of Eligible Pediatric Enrollees, subject to the applicable Premium through the Federally Facilitated Marketplace for this plan at the time of renewal; and

The Responsible Party may not have to make an election through the Federally Facilitated Marketplace in subsequent open enrollment periods to continue coverage for Eligible Pediatric Enrollees. The Responsible Party should refer to the Federally Facilitated Marketplace rules regarding automatic renewal of coverage.

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



Michael G. Hankinson, Esq.
President

Notice to Buyer: This Policy provides dental coverage only. Review Your Policy carefully.

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INTRODUCTION

We are pleased to welcome You to this individual Delta Dental PPO™ dental plan. Our goal is to provide You with the highest quality dental care and to help You maintain good dental health. We encourage You not to wait until You have a problem to see the dentist, but to see one on a regular basis.

Eligibility under this Policy is determined by the Federally Facilitated Marketplace. This Policy provides dental Benefits for adults and children as defined in the following sections:

- **Eligibility Requirement for Pediatric Benefits (Essential Health Benefits)**
- **Eligibility Requirement for Adult Benefits**

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

Using This Policy

This Policy discloses the terms and conditions of Your coverage and is designed to help You make the most of Your dental plan. It will help You understand how the dental plan works and how to obtain dental care. Please read this Policy completely and carefully. Keep in mind that “You” and “Your” mean the Enrollees who are covered under this Policy. “We,” “Us” and “Our” always refer to Delta Dental.

Contact Us

If You have any questions about Your coverage that are not answered here, please visit Our website at deltadentalins.com or call Our Customer Service Center. A Customer Service representative can answer questions You may have about obtaining dental care, help You locate a Delta Dental Provider, explain Benefits, check the status of a claim and assist You in filing a claim.

You can access Our automated information line at 888-857-0314 to obtain information about Your Benefits, claim status or to speak to a Customer Service representative for assistance. If You prefer to write to Us with Your question(s), please mail Your inquiry to the following address:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Identification Number

Please provide the Your identification (“ID”) number to Your Provider whenever You receive dental services. Your ID number should be included on all claims submitted for payment. ID cards are not required, but if You wish to have one You may obtain one by visiting Our website at deltadentalins.com.

DEFINITIONS

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

Accepted Fee: the amount the attending Provider agrees to accept as payment in full for services rendered.

Adult Benefits: dental services under this Policy for people age 19 years and older.

Benefits: the amounts that We will pay for covered dental services under this Policy.

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

Claim Form: the standard form used to file a claim, request a Pre-Treatment Estimate or request prior authorization.

Deductible: a dollar amount that You must satisfy for certain covered services before We begin paying Benefits.

Delta Dental PPO Contracted Fee (“PPO Provider’s Contracted Fee”): the fee for each Single Procedure that a PPO Provider has contractually agreed to accept as payment in full for covered services.

Delta Dental PPO Provider (“PPO Provider”): a Provider who contracts with Us or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental PPO Contracted Fee as payment in full for services provided under a PPO plan. A PPO Provider also agrees to comply with Delta Dental’s administrative guidelines.

Delta Dental Premier® Contracted Fee (“Premier Provider’s Contracted Fee”): the fee for each Single Procedure that a Premier Provider has contractually agreed to accept as payment in full for covered services.

Delta Dental Premier Provider (“Premier Provider”): a Provider who contracts with Us or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental Premier Contracted Fee as payment in full for services provided under a plan. A Premier Provider also agrees to comply with Our administrative guidelines.

Effective Date: the original date the plan starts.

Eligible Dependent: a person who is a dependent of an Eligible Primary and considered to be a Qualified Individual by the Federally Facilitated Marketplace. Eligible Dependents are eligible for either Pediatric Benefits or Adult Benefits as described in this Policy.

Eligible Primary: a person who is considered to be a Qualified Individual by the Federally Facilitated Marketplace. Eligible Primaries are eligible for either Pediatric Benefits or Adult Benefits as described in this Policy.

Eligible Pediatric Individual: a person who is considered to be a Qualified Individual by the Federally Facilitated Marketplace. Eligible Pediatric Individuals are eligible for Pediatric Benefits as described in this Policy.

Enrollee: an Eligible Primary (“Primary Enrollee”), Eligible Dependent (“Dependent Enrollee”) or Eligible Pediatric Individual (“Pediatric Enrollee”) enrolled under this Policy to receive Benefits; persons eligible and enrolled under this Policy for Adult Benefits may also be referred to as “Adult Enrollees.”

Enrollee Pays: Your financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as “Delta Dental Pays” on the claims statement when a claim is processed.

Essential Health Benefits (“Pediatric Benefits”): for the purposes of this Policy, Essential Health Benefits are certain pediatric oral services that are required to be included in this Policy under the Affordable Care Act. The services considered to be Essential Health Benefits are determined by state and federal agencies and are available for Eligible Pediatric Individuals.

Exchange: the Federally Facilitated Marketplace.

Maximum: the maximum dollar amount We will pay toward the cost of dental care.

Maximum Contract Allowance: the reimbursement under the You’s benefit plan against which We calculate Our payment and the financial obligation for You. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by a PPO Provider is the lesser of the Submitted Fee or the PPO Provider’s Contracted Fee; or

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- by a Premier Provider is the lesser of the Submitted Fee or the PPO Provider's Contracted Fee for a PPO Provider in the same geographic area; or
 - by a Non-Delta Dental Provider is the lesser of the Submitted Fee or the PPO Provider's Contracted Fee for a PPO Provider in the same geographic area.

Non-Delta Dental Provider: a Provider who is not a PPO Provider or a Premier Provider and who is not contractually bound to abide by Our administrative guidelines.

Open Enrollment Period: the period of the year that the Federally Facilitated Marketplace has established when the Primary Enrollee may change coverage selections for the next Policy Year.

Out-of-Pocket Maximum: the maximum amount that a Pediatric Enrollee must satisfy for covered dental services during the Calendar Year provided a PPO Provider is used. Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered services from a Premier or Non-Delta Dental Provider even after the Out-of-Pocket Maximum has been met.

Policy: this agreement between Us and the Primary Enrollee including any application supplied by the Federally Facilitated Marketplace and any Attachments. This Policy constitutes the entire agreement between the parties.

Policy Benefit Level: the percentage of the Maximum Contract Allowance that We will pay.

Policyholder: the Primary Enrollee who enrolls for coverage. If this Policy is offered as a child-only or multi-child only Policy by the Federally Facilitated Marketplace, a Primary Enrollee can be an Eligible Pediatric Individual enrolled for coverage by a responsible party, who assumes all responsibilities as a Policyholder. Responsible parties may include: parent, step-parent, adoptive parent, foster parent or Spouse of the Eligible Pediatric Individual.

Policy Year: the 12 months starting on January 1st and each subsequent 12 month period thereafter. Policy Year can be less than 12 months if You have an Effective Date mid-year due to a Qualifying Status Change or other exceptional circumstance as determined by the Federally Facilitated Marketplace.

Premium: the amount payable as provided in the Policy Information attached to this Policy.

Pre-Treatment Estimate: an estimation of the allowable Benefits under this Policy for the services proposed, assuming You are eligible.

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

Provider: a person licensed to practice dentistry when and where services are performed. A Provider will also include a dental partnership, dental professional corporation or dental clinic.

Qualified Individual: an individual determined by the Federally Facilitated Marketplace to be eligible to enroll through the Federally Facilitated Marketplace.

Qualifying Status Change:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- dependent child ceases to satisfy eligibility requirements;
- residence (You move);
- court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by the Federally Facilitated Marketplace.

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

Special Enrollment Period: A time the Federally Facilitated Marketplace has established outside the yearly Open Enrollment Period when You can sign-up for coverage.

Spouse: a person related to the Primary Enrollee as recognized in any legally valid marriage, including a domestic or life partnership comprised of two people of the same or opposite sex.

Submitted Fee: the amount that the Provider bills and enters on a claim for a specific procedure.

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

Waiting Period: the amount of time You must be enrolled under this Policy for specific services to be covered.

ELIGIBILITY AND ENROLLMENT

The Federally Facilitated Marketplace is responsible for establishing eligibility and reporting enrollment to Us. We process enrollment as reported by the Federally Facilitated Marketplace.

This Policy includes Pediatric Benefits and Adult Benefits. You are eligible for either Pediatric or Adult Benefits according to the requirements listed below:

Eligibility Requirement for Pediatric Benefits

Pediatric Enrollees are Qualified Individuals as determined by the Federally Facilitated Marketplace who are eligible and have enrolled for Pediatric Benefits under this Policy. A Qualified Individual must satisfy the Federally Facilitated Marketplace's requirements regarding:

- citizenship, status as a national or otherwise lawfully present in the United States;
- incarceration; and
- residency.

Pediatric Enrollees eligible for Pediatric Benefits are:

- a Primary Enrollee or an emancipated minor to age 19; and/or
- a Primary Enrollee's Spouse under age 19 and dependent children from birth to age 19. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption, children of Spouse, and children as required by a court or administrative order and as may be recognized by the Contractholder. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Legally adopted children are eligible beginning from the moment of birth, if placement for adoption occurs within 30 days of the child's birth or beginning from the date of placement, if placement for adoption occurs 30 days or more after the child's birth. Notice of birth, adoption, placement or marriage and payment of appropriate premium must be received within 30 days after the date of birth, adoption, placement or marriage for coverage to continue beyond 30 days.

Eligibility Requirement for Adult Benefits

Primary Enrollees and Dependent Enrollees are Qualified Individuals as determined by the Federally Facilitated Marketplace who are eligible and have enrolled for Adult Benefits under this Policy. A Qualified Individual must satisfy the Federally Facilitated Marketplace's requirements regarding:

- citizenship, status as a national or otherwise lawfully present in the United States;
- incarceration; and
- residency.

Adult Enrollees eligible for Adult Benefits are:

- a Primary Enrollee age 19 years of age or older; and/or
- a Primary Enrollee's Spouse age 19 and older and dependent children from age 19 to age 26. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption, children of Spouse, as required by a court or administrative order and as may be recognized by the Contractholder. Legally adopted children are eligible beginning from the moment of birth, if placement for adoption occurs within 30 days of the child's birth or beginning from the date of placement, if placement for adoption occurs 30 days or more after the child's birth. Additional premiums, if applicable and enrollment of the newborn or adopted children must be given within 31 days after the child's date of birth or placement for adoption.

A dependent unmarried child 26 years of age or older who has been continuously covered with no break of more than 63 days may continue eligibility for Adult Benefits if:

1. "Disabled with a disability" a child who is and continues to be both:
 - (i) unable to engage in substantial gainful employment to the degree that the child can achieve economic due to a medically determinable physical or mental impairment which can be expected to result in death, or has lasted or can be expected to last for a continuous period of not less than 12 months; and
 - (ii) chiefly dependent upon an insured for support and maintenance since the child reached the age of 26.
2. proof of impairment is provided within 30 days of request. Such requests will not be made more than once a year following a two year period after this 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 that began before they reached the limiting age. Eligibility will continue as long as the dependent relies on the Primary Enrollee or Spouse for support because of a mental or physical impairment that began before they reached the limiting age.

Renewal

This Policy remains in effect for the Policy Year, provided it is not terminated by Us or by the Primary Enrollee. The Primary Enrollee will receive renewal information from the Federally Facilitated Marketplace prior to any applicable Open Enrollment Period. The Primary Enrollee may change plan selections with the Federally Facilitated Marketplace during the Open Enrollment Period. Provided We continue to make this Policy available through the Federally Facilitated Marketplace at the renewal period:

- You may elect to choose this Policy, subject to the applicable Premium through the Federally Facilitated Marketplace for this plan at the time of renewal; or
- You may not have to make an election through the Federally Facilitated Marketplace in subsequent Open Enrollment Periods to continue coverage. You should refer to the Federally Facilitated Marketplace rules regarding automatic renewal of coverage.

Termination of Coverage

You have the right to terminate coverage under this Policy by sending the Federally Facilitated Marketplace written notice of intent to terminate this Policy. The effective date of termination will be the date reported by the Federally Facilitated Marketplace. If coverage is terminated because You are covered by Medicaid, the last day of coverage with Us is the day before the new coverage is effective.

A full refund of Premium is available if a written request for a refund is made within the first 10 days of the Effective Date.

You may keep this Policy in force by timely payment of the Premiums. However, We may terminate coverage due to:

- You no longer being eligible through the Federally Facilitated Marketplace or under the terms of this Policy;
- non-payment of Premiums, subject to the “*Grace Period on Late Payments*” provision;
- fraud or material misrepresentation made by or with the knowledge of the Primary Enrollee or the Enrollee applying for this coverage or filing a claim for Benefits;
- the Primary Enrollee changing to a new policy through the Federally Facilitated Marketplace; or
- We cease to renew all Policies issued on this form to residents of the state where You live.

If Your coverage is terminated, We will send a written notice to You informing You of the reasons(s) why coverage is terminated and the date that Your coverage will end. We will not pay for services received after the date coverage ends. However, We will pay for the completion of Single Procedures started while You were eligible if they are completed within 31 days of the date coverage ended.

If termination is due to loss of eligibility through the Federally Facilitated Marketplace, termination is effective the last day of the month following the month that the Federally Facilitated Marketplace notifies You of lack of eligibility. If You are no longer eligible due to age, termination is effective on the date reported by the Federally Facilitated Marketplace and You should contact the Federally Facilitated Marketplace to see if Special Enrollment Periods apply.

Reinstatement

If this Policy is terminated, You may re-enroll in the plan at the next Open Enrollment Period. Any Deductible, Maximum, Out-of-Pocket Maximum and/or Waiting Period applicable to Your Benefits will start over. However, this Policy may be reinstated prior to Open Enrollment with no break in coverage provided the full Premium due is received by Us (see “*Grace Period on Late Payments*”). The reinstated Policy will have the same rights as before Your Policy lapsed, unless a change is made to this Policy in connection with the reinstatement. These changes, if any, will be sent to You for You to attach to this Policy.

If any renewal Premium is not paid within the Premium grace period You for payment, a subsequent acceptance of Premium by Us or by any agent duly authorized by the insurer to accept the Premium, without also requiring an application for reinstatement, will reinstate the policy. However, if We or agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Policy will be reinstated upon approval of this application from You or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless We have previously notified You in writing of its disapproval of the application. The reinstated policy will cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after the date. In all other respects You and Delta Dental have the same rights under the reinstated Policy as they had under the Policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed on or attached to this Policy in connection with the reinstatement. Any Premium accepted in connection with a reinstatement will be applied to a period for which Premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

OVERVIEW OF DENTAL BENEFITS

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

Benefits, Limitations and Exclusions

We will pay Benefits for the types of dental services as described in the Attachments that are a part of this Policy.

We will pay Benefits only for covered services. This Policy covers several categories of Benefits when a Provider furnishes the services and when they are necessary and within the standards of generally accepted dental practice. Claims will be processed in accordance with Our standard processing policies. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. If You receive dental services from a Provider outside the state of Utah, the Provider will be paid according to Our network payment provisions for said state and according to terms of this Policy.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under this Policy. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, subject to certain limitations, and You are responsible for paying the balance. What You pay is called Your coinsurance (“Enrollee Coinsurance”) and is part of Your out-of-pocket cost. You may have to satisfy a Deductible before We will pay Benefits. You pay Your Coinsurance even after a Deductible has been met.

The amount of Your Coinsurance will depend on the type of service and the Provider furnishing the service (see section titled “*Selecting Your Provider*”). Providers are required to collect Your Coinsurance for covered services. If the Provider discounts, waives or rebates any portion of Your Coinsurance to You, We will be obligated to provide as Benefits only the applicable percentages of the Provider’s fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to Your advantage to select PPO Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for You. Please refer to the section titled “*Selecting Your Provider*” for more information.

Pre-Treatment Estimates

Pre-Treatment Estimate requests are not required; however, Your Provider may file a Claim Form before beginning treatment, showing the services to be provided to You. We will estimate the amount of Benefits payable under this Policy for the listed services. By asking Your Provider for a Pre-Treatment Estimate from Us before the You receives any prescribed treatment, You will have an estimate up front of what We will pay and the difference You will need to pay. The Benefits will be processed according to the terms of this Policy when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days or until an earlier occurrence of any one of the following events:

- the date this Policy terminates;
- the date Your coverage ends; or
- the date the Provider’s agreement with Us ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount We will pay if You are covered and meet all the requirements of the plan at the time the treatment You have planned is completed and may not take into account any Deductibles, so please remember to figure in Your Deductible if necessary.

SELECTING YOUR PROVIDER

Free Choice of Provider

You may see any Provider for Your covered treatment whether the Provider is a PPO Provider, Premier Provider or a Non-Delta Dental Provider. **This plan offered through the Federally Facilitated Marketplace is a PPO plan and the greatest benefits – including out-of-pocket savings – occur when You choose a PPO Provider.** To take full advantage of Your Benefits, We highly recommend You verify a Provider's participation status within a Delta Dental network with Your dental office before each appointment. Review this section for an explanation of Our payment procedures to understand the method of payments applicable to Your Provider selection and how that may impact Your out-of-pocket costs.

Locating a PPO Provider

You may access information through Our website at deltadentalins.com. You may also call Our Customer Service Center and one of Our representatives will assist You. We can provide You with information regarding a Provider's network participation, specialty and office location.

Choosing a PPO Provider

The PPO plan potentially allows the greatest reduction in Your out-of-pocket expenses since this select group of Providers will provide dental Benefits at a charge that has been contractually agreed upon. Payment for covered services performed by a PPO Provider is based on the Maximum Contract Allowance.

Costs incurred by the Pediatric Enrollee for covered services with a PPO Provider apply towards the Out-of-Pocket Maximum for Pediatric Benefits.

Choosing a Premier Provider

A Premier Provider is a Delta Dental Provider; however, the Premier Provider has not agreed to the features of the PPO plan. The amount charged may be above that accepted by PPO Providers, and You will be responsible for balance billed amounts. Payment for covered services performed by a Premier Provider is based on the Maximum Contract Allowance, and You may be balance billed up to the Premier Provider's Contracted Fee.

Costs incurred by the Pediatric Enrollee with a Premier Provider do not count towards the Out-of-Pocket Maximum for Pediatric Benefits. Coinsurance and other cost-sharing, including balance billed amounts, continue to apply when a Premier Provider is used even if the Out-of-Pocket Maximum for Pediatric Enrollees has been met.

Choosing a Non-Delta Dental Provider

If a Provider is a Non-Delta Dental Provider, the amount charged to You may be above that accepted by PPO Providers or Premier Providers, You will be responsible for balance billed amounts. Payment for covered services performed by a Non-Delta Dental Provider is based on the Maximum Contract Allowance, and You may be balance billed up to the Provider's Submitted Fee.

Costs incurred by You with a Non-Delta Dental Provider do not count towards the Out-of-Pocket Maximum for Pediatric Benefits. Your Coinsurance and other cost-sharing, including balance billed amounts, continue to apply when a Non-Delta Dental Provider is used even if the Out-of-Pocket Maximum for Pediatric Enrollees has been met.

Additional Obligations of PPO and Premier Providers

- The PPO Provider or Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Us after satisfaction of the Deductible and Your Coinsurance. You do not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Provider or Premier Provider will complete the dental Claim Form and submit it to Us for reimbursement.
- The PPO Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Delta Dental PPO Contracted Fees.

How to Submit a Claim

Claims for Benefits must be filed on a standard Claim Form that is available in most dental offices. PPO and Premier Providers will fill out and submit Your claims paperwork for You. Some Non-Delta Dental Providers may also provide this service upon Your request. If You receive services from a Non-Delta Dental Provider who does not provide this service, You can submit Your own claim directly to Us. Please refer to the section titled “*Claim Form*” for more information.

Your dental office should be able to assist You in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Payment Guidelines

We do not pay PPO or Premier Providers any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If the services were received from a Non-Delta Dental Provider, You are still responsible for the full cost. If the payment is denied because Your PPO or Premier Provider failed to submit the claim on time, You may not be responsible for that payment.

If You have any questions about any dental charges, processing policies and/or how Your claim is paid, please contact Us.

Provider Relationships

You and Delta Dental agree to permit and encourage the professional relationship between Provider and You to be maintained without interference. Any PPO, Premier or Non-Delta Dental Provider, including any Provider or employee associated with or employed by them, who provides dental services You does so as an independent contractor and will be solely responsible for dental advice and for performance of dental services, or lack thereof, to You.

GRIEVANCES AND APPEALS

If You have questions about any services received, We recommend that You first discuss the matter with Your Provider. However, if You continue to have concerns, please call Our Customer Service Center. You can also email questions by accessing the “Contact Us” section of Our website at deltadentalins.com.

Grievances regarding eligibility, the denial of dental services or claims, the policies, procedures, Our operations or the quality of dental services performed by the Provider may be directed in writing to Us or by calling Us toll-free at 888-857-0314.

When You write, please include Your name, Your ID number and Your telephone number on all correspondence. You should also include a copy of the Claim Form, claim statement or other relevant information. Your claim statement will have an explanation of the claim review and any grievance process and time limits applicable to such process.

We will notify You and Your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. You and Your Provider have at least 180 days after receiving a notice of denial to request a review in writing to Us giving reasons why You believe the denial was wrong. You may also ask Us to examine any additional information You include that may support Your grievance.

Send Your grievance to Us at the address shown below:

Delta Dental Insurance Company
P.O. Box 1860
Alpharetta, GA 30023-1860

We will send You a written acknowledgment within five (5) days upon receipt of Your grievance. We will make a full and fair review within 30 days after We receive the grievance. We may ask for more documents if needed. We will send You a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Policy, We will consult with a dentist who has appropriate training and experience. The review will be conducted for Us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

If the complaint involves an adverse benefit determination You have the right to file a request for independent review of the final adverse benefit determination. You must file the request for an independent review within 180 days after receipt of the notice of a final denial by contacting the Utah Insurance Commissioner by mail at 4315 S 2700 W Ste 2300 Taylorsville, UT 84129; by telephone at 801-957-9200; or electronically at healthappeals.uid@utah.gov

Appeals

If You believe You need further review of Your claim, You may contact Your state insurance regulatory agency.

PREMIUM PAYMENT RESPONSIBILITIES

Your Premium is determined by the plan design chosen at the time of enrollment. Premiums are listed in the Policy Information attached to this Policy. You are responsible for making Premium payments.

Each Premium is to be paid on or before its due date. A due date is the day following the last day of the period for which the preceding Premium was paid. You may pay Your Premium by visiting Our website at deltadentalins.com or by mailing payment to the address below:

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

Rate Guarantee

Your Premium rate is guaranteed for each Policy Year based upon the new Enrollee rates in force at the time of Your enrollment. The rate guarantee can be less than 12 months if You have an Effective Date mid-year due to a Qualifying Status Change or due to other extraordinary circumstance as determined by the Federally Facilitated Marketplace.

Notice of premium change will be given no fewer than 45 days prior to the renewal date.

Changing Payment Options

Payment options may be changed at any time. The effective date of any change is the date of the next scheduled payment based on Your new billing period. You can change Your payment option by visiting Our website at deltadentalins.com or by contacting Our Customer Service Center toll-free at 888-857-0314.

Grace Period on Late Payments

For Enrollees receiving an Advanced Premium Tax Credit (APTC):

- If Your Premium payment is not received by the first of the month, a grace period of three (3) months will be granted. During the grace period, this Policy will continue in force. However, Your coverage for the second and third months of the grace period will be suspended and claims incurred during the second and third months of the grace period will not be paid unless all Premiums due are paid prior to the expiration of the grace period. If Premiums are received during the grace period, then You will be reinstated as of the last day of paid coverage. If Premiums are not received prior to the end of the grace period, coverage will be terminated as of the end of the last day of the first month of the grace period.

For Enrollees not receiving an Advanced Premium Tax Credit (non-APTC):

- A grace period of 31 days will be granted for the payment of each Premium falling due after the first Premium. During this time this Policy will continue in force. Coverage will terminate at the end of the grace period unless We receive Your Premium before the end of this 31 days.

GENERAL PROVISIONS

Entire Contract; Changes

This Policy, including any application and Attachments, constitutes the entire contract of insurance. No change to this Policy will be valid until approved by Our executive officer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Severability

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

Incontestability

After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for this Policy will be used to void this Policy or to deny a claim for loss incurred or disability commencing after the expiration of such 2-year period.

No claim for loss incurred or disability commencing after two (2) years from the date of issue of this Policy will be reduced or denied on the grounds 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 Policy.

Clinical Examination

Before approving a claim, We will be entitled to receive, to such extent as may be lawful, information and records relating to the treatment provided to You as may be required to administer the claim. Examination may be required by a dental consultant retained by Us in or near Your community or residence. We will in every case hold such information and records confidential.

Written Notice of Claim/Proof of Loss

We must be given written proof of loss within 12 months after the date of the loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give written proof in the time required, provided that the proof is filed as soon as reasonably possible. A notice of claim submitted by You, on Your behalf, or on behalf of Your beneficiary to Us or to Our authorized agent, with information sufficient to identify You will be considered notice of claim.

All written proof of loss must be given to Us within 12 months of the termination of this Policy. Failure to give notice or file proof of loss as required does not bar recovery under the policy if the insurer fails to show it was prejudiced by the failure.

Claim Form

We will within 15 days after receiving a notice of a claim provide You or Your Provider with a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to Us at the address above.

If We do not send You or Your Provider a Claim Form within 15 days after You or Your Provider gave Us notice regarding a claim, the requirements for proof of loss outlined in the section "*Written Notice of Claim/Proof of Loss*" above will be deemed to have been complied with as long as You give Us written proof that explains the type and the extent of the loss that You are making a claim for within the time established for filing proofs of loss. You may also download a Claim Form from Our website at deltadentalins.com.

Time of Payment

Claims payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be processed no later than 30 days after written proof of loss is received in the form required by the terms of this Policy. If We are unable to make a decision within the time due to circumstances beyond Our control, such as late receipt of medical records, We will notify You or Your Provider before the expiration of the original 30 days that We intend to extend the time for up to 15 additional days to reach a decision. If the extension is due to failure to receive necessary information, the extension notice of the delay will provide specific information about what has to be provided and will provide You and Your Provider with an additional 45 days to submit the requested information. We will notify You and Your Provider of any additional information needed to process the claim within this 30 day period.

Claims not processed as stated above are subject to a late fee as determined below provided the late fee is more than \$1:

For the first 90 days the late fee will be determined by multiplying:

- The total amount of the claim;
- The total number of days the payment is late; and
- 1%

For a claim that is 91 days or more late, the late fee will be determined by adding together:

- The late fee for the 90-day period as determined under the above bullet time; and
- The following multiple together;
 - a) The total amount of the claim;
 - b) The total number of days the payment was late beyond the initial 90 day period; and
 - c) 10%

To Whom Benefits Are Paid

It is not required that the service be provided by a specific Provider. Payment for services provided by a PPO or Premier Provider will be made directly to the Provider. Any other payments provided by this Policy will be made to You unless You request in writing when filing a proof of claim that the payment be made directly to the Provider providing the services. All Benefits not paid to the Provider will be payable to You or to Your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to their parent, guardian or other person actually supporting them.

Misstatements on Application; Effect

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

We may not cancel Your policy based on a statement made by the applicant relating to Your insurability, except in case of fraudulent misrepresentation, may not be a basis for avoidance of this Policy, coverage, or denial of a claim for loss incurred or disability commencing after the coverage has been in effect for two (2) years.

Legal Actions

No action at law or in equity will be brought to recover on this Policy prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of this Policy. No action can be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by this Policy.

Conformity with Applicable Laws

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

Holding Company

We are a member of the insurance holding company system of Delta Dental of California (the "Enterprise"). There are service agreements between and among the controlled member companies of the Enterprise. We are party to some of these service agreements. It is expected that the services, which include certain ministerial tasks, will continue to be performed by these controlled member companies, which operate under strict confidentiality and/or business associate agreements. All such service agreements have been approved by the respective regulatory agencies.

Third Party Administrator (“TPA”)

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

Impossibility of Performance

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

Non-Discrimination

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

We:

- Provides free aids and services to people with disabilities to communicate effectively with Us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If You need these services, contact Our Customer Service Center at 888-857-0314.

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
P.O. Box 997330
Sacramento, CA 95899-7330
Telephone Number: 888-857-0314
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>.

NOTICE OF PROTECTION PROVIDED THE BY UTAH LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This disclaimer provides a **brief summary** of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. The safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that Your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with the funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
 - \$500,000 in death benefits
 - \$200,000 in cash surrender or withdrawal values
- Accident and Health Insurance
 - \$500,000 for health benefit plans
 - \$500,000 in disability income insurance benefits
 - \$500,000 in long-term care insurance benefits
 - \$500,000 in other types of health insurance benefits
- Annuities
 - \$250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to health benefit plans.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract will be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, please visit the Association's website at www.ulhiga.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
466 South 500 East, Suite 100
Salt Lake City, UT 84102
(801) 320-9955

Utah Insurance Department
4315 S. 2700 W., Suite 2300
Taylorsville, UT 84129
(801) 957-9200

Delta Dental Insurance Company
(A Delaware Corporation)
1130 Sanctuary Parkway
Alpharetta, GA 30009

POLICY INFORMATION

Policyholder:

Effective Date:

Policy Year:

Policy ID Number:

Premium Remittance:

Each Premium is to be paid to:
Delta Dental Insurance Company
P.O. Box 660138
Dallas, TX 75266-0138

Monthly Premium:

Attachment A Deductibles, Maximums, Policy Benefit Levels and Enrollee Coinsurances

Deductibles & Maximums		
	Adult Benefits (age 19 and older)	Pediatric Benefits (under age 19)
Annual Deductible		
Enrollee	\$50 each Calendar Year	No annual Deductible
Family (three or more Enrollees)	\$150 each Calendar Year	
Annual Maximum		
Enrollee	\$1,000 each Calendar Year	No annual Maximum
Out-of-Pocket Maximum*		
Pediatric Enrollee	\$400 each Calendar Year for only one covered Pediatric Enrollee	
Multiple Pediatric Enrollees	\$800 each Calendar Year for two or more covered Pediatric Enrollees	

* Out-of-Pocket Maximum applies only to Essential Health Benefits that are provided by Delta Dental PPO Providers for Pediatric Enrollees. Once the amount paid by Pediatric Enrollee(s) equals the Out-of-Pocket Maximum, no further payment will be required by the Pediatric Enrollee(s) for the remainder of the Calendar Year for covered services received from Delta Dental PPO Providers. Enrollee Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Delta Dental Premier or Non-Delta Dental Providers even after the Out-of-Pocket Maximum is met.

If two or more Pediatric Enrollees are covered, the financial obligation for covered services received from Delta Dental PPO Providers is not more than the multiple Pediatric Enrollees Out-of-Pocket Maximum. However, once a Pediatric Enrollee meets the Out-of-Pocket Maximum for one covered Pediatric Enrollee, that Pediatric Enrollee will have satisfied their Out-of-Pocket Maximum. Other covered Pediatric Enrollees must continue to pay Enrollee Coinsurance for covered services received from Delta Dental PPO Providers until the total amount paid reaches the Out-of-Pocket Maximum for multiple Pediatric Enrollees.

Policy Benefit Levels & Enrollee Coinsurances				
	Adult Benefits (age 19 and older)		Pediatric Benefits (under age 19)	
Dental Service Category	Delta Dental PPO¹		Delta Dental PPO¹	
	Delta Dental ²	Enrollee ²	Delta Dental ²	Enrollee ²
Diagnostic and Preventive Services	100%	0%	70%	30%
Basic Services	50%	50%	Not a covered benefit	Not a covered benefit
Waiting Periods	No Waiting Periods			

¹ Reimbursement is based on Delta Dental PPO Contracted Fees for Delta Dental PPO, Delta Dental Premier and Non-Delta Dental Providers.

²Delta Dental will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for covered services. Note: Delta Dental will pay the same Policy Benefit Level for covered services performed by a PPO Provider, Premier Provider and a Non-Delta Dental Provider. However, the amount charged to Enrollees for covered services performed by a Premier Provider or Non-Delta Dental Provider may be above that accepted by PPO Providers, and Enrollees will be responsible for balance billed amounts.

Attachment B Services, Limitations and Exclusions

Description of Dental Services for Adult Benefits (Age 19 and Older)

We will pay or otherwise discharge the Policy Benefit Level shown in Attachment A for the following services:

- **Diagnostic and Preventive Services**

- (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
- (2) Preventive: routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation - full mouth.

- **Basic Services**

- (1) Palliative: emergency treatment to relieve pain.
- (2) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

- **Note on additional Benefits during pregnancy**

When an Enrollee is pregnant, We will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Policy include one (1) additional oral exam and one (1) additional routine cleaning. Written confirmation of the pregnancy must be provided by the Enrollee or the Enrollee's Provider when the claim is submitted.

Limitations for Adult Benefits (Age 19 and Older)

- (1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. An example of an Optional Service is a composite restoration instead of an amalgam restoration on posterior teeth.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means We will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.
- (2) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Policy. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.
- (3) We will pay for oral examinations (except after hours exams and exams for observation) and routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) no more than twice in a Calendar Year. See note on additional Benefits during pregnancy.
- (4) A caries risk assessment is allowed once in 12 months.
- (5) Application of caries arresting medicament is limited to twice per tooth per Calendar Year.

- (6) X-ray limitations:
 - a) We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
 - b) When a panoramic film is submitted with supplemental film(s), We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
 - c) If a panoramic film is taken in conjunction with an intraoral complete series, We consider the panoramic film to be included in the complete series.
 - d) A complete intraoral series and panoramic film are each limited to once every 60 months.
 - e) Bitewing x-rays are limited to one (1) time each Calendar Year. Bitewings of any type are not billable to the Enrollee or Delta Dental within six (6) months of a full mouth series.
 - f) Image capture procedures are not separately allowable services.
- (7) Pulp vitality tests are allowed once per day when definitive treatment is not performed.
- (8) Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a 12-month period and included if reported, with any other examination on the same date of service and Provider office.
- (9) We will not cover to replace amalgam and resin-based composite restorations (fillings) and prefabricated restorations within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations, including reattachment of a tooth fragment, within 24 months are included in the fee for the original restoration.
- (10) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- (11) Pin retention is covered not more than once in any 24-month period.
- (12) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.
- (13) The fees for synchronous/asynchronous Teledentistry services are considered inclusive in overall patient management and are not separately payable services.

Exclusions for Adult Benefits (Age 19 and Older)

We do not pay Benefits for:

- (1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- (2) cosmetic surgery or procedures for purely cosmetic reasons.
- (3) maxillofacial prosthetics.
- (4) provisional and/or temporary restorations.
- (5) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.
- (6) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
- (7) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- (8) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- (9) interim implants.

- (10) indirectly fabricated resin-based Inlays/Onlays.
- (11) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- (12) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- (13) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.
- (14) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- (15) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- (16) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.
- (17) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.
- (18) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- (19) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric x-rays, oral/facial photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.
- (20) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.
- (21) endodontic endosseous implants.
- (22) services or supplies for sealants, fluoride, space maintainers, apexification and transeptal fiberotomy/supra crestal fiberotomy.
- (23) services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.
- (24) services or supplies for oral surgery, general anesthesia or IV sedation.
- (25) services or supplies for endodontic treatment (procedures for removal of the nerve of the tooth and the treatment of the pulp cavity portion of the root of the tooth).
- (26) services or supplies for periodontic treatment (procedures for the treatment of the gums and the bones supporting teeth).
- (27) services or supplies for denture repairs (repair to partial or complete dentures including rebase procedures and relining).
- (28) services or supplies for crowns and inlays/onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, or plastic restorations.
- (29) services or supplies for prosthodontics (procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges).
- (30) missed and/or cancelled appointments.
- (31) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

- (32) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- (33) dental case management motivational interviewing and patient education to improve oral health literacy.
- (34) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- (35) extra-oral - 2D projection radiographic image and extra-oral posterior dental radiographic image.
- (36) diabetes testing.
- (37) corticotomy (specialized oral surgery procedure associated with orthodontics).
- (38) antigen or antibody testing.
- (39) counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

Description of Dental Services for Pediatric Benefits (Under Age 19)

We will pay or otherwise discharge the Policy Benefit Level shown in Attachment A for Essential Health Benefits when provided by a Provider and when necessary and customary under generally accepted dental practice standards

- **Diagnostic and Preventive Services**

- (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
- (2) Preventive: cleanings, including scaling in presence of generalized moderate or severe gingival inflammation - full mouth, topical application of fluoride solutions.
- (3) Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

- **Note on additional Benefits during pregnancy**

When an Enrollee is pregnant, We will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Policy include one (1) additional oral exam and one (1) additional routine cleaning. Written confirmation of the pregnancy must be provided by the Enrollee or the Enrollee's Provider when the claim is submitted.

Limitations for Pediatric Benefits (Under Age 19)

- (1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means We will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.
- (2) Claims shall be processed in accordance with Our standard processing policies. The processing policies may be revised from time to time; therefore, We shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.
- (3) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Policy. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

- (4) We will pay for oral examinations (except after hours exams and exams for observation), cleanings (including scaling in presence of generalized moderate or severe gingival inflammation or any combination thereof) and topical application of fluoride solutions no more than twice in a Calendar Year. See note on additional Benefits during pregnancy.
- (5) Application of caries arresting medicament is limited to twice per tooth per Calendar Year.
- (6) X-ray limitations:
 - a) We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
 - b) When a panoramic film is submitted with supplemental film(s), We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
 - c) If a panoramic film is taken in conjunction with an intraoral complete series, We consider the panoramic film to be included in the complete series.
 - d) A complete intraoral series and panoramic film are each limited to once every 36 months.
 - e) Bitewing x-rays are limited to once every six (6) months. Bitewings of any type are not billable to the Enrollee or Delta Dental within six (6) months of a full mouth series.
 - f) Image capture procedures are not separately allowable services.
- (7) Caries risk assessments are allowed once in 12 months.
- (8) Sealants are limited as follows:
 - a) once every 60 months to permanent first and second molars through age 18 if they are without caries (decay) or restorations on the occlusal surface.
 - b) do not include repair or replacement of a sealant on any tooth within 60 months of its application.
- (9) Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a 12-month period and included if reported, with any other examination on the same date of service and Provider office.
- (10) The fees for synchronous/asynchronous Teledentistry services are considered inclusive in overall patient management and are not separately payable services.

Exclusions for Pediatric Benefits (Under Age 19)

We do not pay Benefits for:

- (1) services that are not Essential Health Benefits.
- (2) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- (3) cosmetic surgery or procedures for purely cosmetic reasons.
- (4) maxillofacial prosthetics.
- (5) provisional and/or temporary restorations.
- (6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments, or Night Guards/Occlusal guards and abfraction.
- (7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
- (8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- (9) charges for anesthesia.
- (10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- (11) laboratory processed crowns.

- (12) fixed bridges and removable partials.
- (13) interim implants.
- (14) indirectly fabricated resin-based inlays/onlays.
- (15) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- (16) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- (17) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.
- (18) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- (19) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- (20) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.
- (21) Deductibles and/or any service not covered under the dental plan.
- (22) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- (23) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.
- (24) endodontic endosseous implant.
- (25) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric x-rays, oral/facial photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.
- (26) services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.
- (27) services or supplies for oral surgery, general anesthesia or IV sedation.
- (28) services or supplies for endodontic treatment (procedures for removal of the nerve of the tooth and the treatment of the pulp cavity portion of the root of the tooth).
- (29) services or supplies for periodontic treatment (procedures for the treatment of the gums and the bones supporting teeth).
- (30) services or supplies for restorative treatment (amalgam or resin based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- (31) services or supplies for denture repairs (repair to partial or complete dentures including rebase procedures and relining).
- (32) services or supplies for crowns and inlays/onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composite restorations.
- (33) services or supplies for prosthodontics (procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges).
- (34) palliative (emergency) treatment to relieve pain.

- (35) missed and/or cancelled appointments
- (36) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- (37) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- (38) dental case management motivational interviewing and patient education to improve oral health literacy.
- (39) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- (40) extra-oral posterior dental radiographic image.
- (41) diabetes testing.
- (42) antigen or antibody testing.
- (43) counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.



A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

Delta Dental Insurance Company
(A Delaware Corporation)
P.O. Box 1809
Alpharetta, GA 30023-1809
888-857-0314
deltadentalins.com

Delta Dental Individual and Family™

Delta Dental PPO™
Basic Plan for Families

Outline of Coverage

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL DENTAL EXPENSES

Read your Policy carefully. This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance Policy and only the Policy provisions will control.

The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is therefore important that you READ YOUR POLICY CAREFULLY. The Policy provides benefits for dental care only.

If you are not satisfied with the Policy for any reason, you may return the Policy within 10 days after you receive it. Mail or deliver it to Delta Dental Insurance Company ("Delta Dental"). Any premium paid will be refunded. The Policy will then be void from its start.

Note: Persons eligible for Medicare have the right to return this Policy for any reason within thirty (30) days after its delivery and will have the premium refunded.

IMPORTANT: In the event of any inconsistency between this Outline of Coverage and the Policy the terms of the Policy will control.

Delta Dental Individual & Family™

Delta Dental PPO™
Basic Plan for Families

Plan Highlights	Pediatric Benefits (up to age 19)		Adult Benefits (19 and older)	
Annual Deductible & Maximums				
Deductible				
Enrollee	None		\$50 each Calendar Year	
Family	None		\$150 each Calendar Year	
Annual Maximum Maximum the plan will pay each year for services per person	None		\$1,000 each Calendar Year	
Out-of-Pocket Maximum After this amount is reached, the plan pays 100% of the remaining covered services for that Calendar Year.	\$400 each Calendar Year for only one covered Pediatric Enrollee		None	
	\$800 each Calendar Year for two or more covered Pediatric Enrollees			
Waiting Period(s)	None		None	
Covered Services*	<i>Delta Dental¹ pays</i>	<i>Enrollee¹ pays</i>	<i>Delta Dental¹ pays</i>	<i>Enrollee¹ pays</i>
Diagnostic & Preventive Services	70%	30%	100%	0%
Basic Services	Not a covered benefit	Not a covered benefit	50%	50%

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement to dentists is based on contracted fees for all dental providers.

¹ Reimbursement is based on Delta Dental PPO Contracted Fees for Delta Dental PPO, Delta Dental Premier and Non-Delta Dental Providers. Note: Delta Dental will pay the same Policy Benefit Level for covered services performed by a PPO Provider, Premier Provider and a Non-Delta Dental Provider. However, the amount charged to Enrollees for covered services performed by a Premier Provider or Non-Delta Dental Provider may be above that accepted by PPO Providers, and Enrollees will be responsible for balance billed amounts.

This benefit information is only a summary and not intended or designed to replace or serve as the plan Policy. Please consult the Policy for a complete description of plan benefits, limitations and exclusions. In the event of any inconsistency between this document and the Policy, the terms of the Policy will prevail.

Limitations and Exclusions

A. Limitations for Pediatric Benefits (Under Age 19)

- (1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which We will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

- (2) Claims will be processed in accordance with Our standard processing policies. The processing policies may be revised from time to time; therefore, We will use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.
- (3) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Policy. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.
- (4) We will pay for oral examinations (except after hours exams and exams for observation), cleanings (including scaling in presence of generalized moderate or severe gingival inflammation or any combination thereof) and topical application of fluoride solutions no more than twice in a Calendar Year. See note on additional Benefits during pregnancy.
- (5) Application of caries arresting medicament is limited to twice per tooth per Calendar Year.
- (6) X-ray limitations:
 - a) We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
 - b) When a panoramic film is submitted with supplemental film(s), We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
 - c) If a panoramic film is taken in conjunction with an intraoral complete series, We consider the panoramic film to be included in the complete series.
 - d) A complete intraoral series and panoramic film are each limited to once every 36 months.
 - e) Bitewing x-rays are limited to once every six (6) months. Bitewings of any type are not billable to the Enrollee or Delta Dental within six(6) months of a full mouth series.
 - f) Image capture procedures are not separately allowable services.
- (7) Caries risk assessments are allowed once in 12 months.
- (8) Sealants are limited as follows:
 - a) once every 60 months to permanent first and second molars through age 18 if they are without caries (decay) or restorations on the occlusal surface.
 - b) do not include repair or replacement of a sealant on any tooth within 60 months of its application.
- (9) Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a 12-month period and included if reported, with any other examination on the same date of service and Provider office.
- (10) The fees for synchronous/asynchronous Teledentistry services are considered inclusive in overall patient management and are not separately payable services.

B. Exclusions for Pediatric Benefits (Under Age 19)

We do not pay Benefits for:

- (1) services that are not Essential Health Benefits.
- (2) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- (3) cosmetic surgery or procedures for purely cosmetic reasons.
- (4) maxillofacial prosthetics.
- (5) provisional and/or temporary restorations.
- (6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments, or Night Guards/Occlusal guards and abfraction.
- (7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
- (8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- (9) charges for anesthesia.
- (10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- (11) laboratory processed crowns.
- (12) fixed bridges and removable partials.
- (13) interim implants.
- (14) indirectly fabricated resin-based inlays/onlays.
- (15) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- (16) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- (17) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.
- (18) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- (19) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

- (20) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.
- (21) Deductibles and/or any service not covered under the dental plan.
- (22) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- (23) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.
- (24) endodontic endosseous implant.
- (25) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric x-rays, oral/facial photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.
- (26) services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.
- (27) services or supplies for oral surgery, general anesthesia or IV sedation.
- (28) services or supplies for endodontic treatment (procedures for removal of the nerve of the tooth and the treatment of the pulp cavity portion of the root of the tooth).
- (29) services or supplies for periodontic treatment (procedures for the treatment of the gums and the bones supporting teeth).
- (30) services or supplies for restorative treatment (amalgam or resin based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- (31) services or supplies for denture repairs (repair to partial or complete dentures including rebase procedures and relining).
- (32) services or supplies for crowns and inlays/onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composite restorations.
- (33) services or supplies for prosthodontics (procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges).
- (34) palliative (emergency) treatment to relieve pain.
- (35) missed and/or cancelled appointments.
- (36) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- (37) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- (38) dental case management motivational interviewing and patient education to improve oral health literacy.
- (39) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

- (40) extra-oral posterior dental radiographic image.
- (41) diabetes testing.
- (42) antigen or antibody testing.
- (43) counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

C. Limitations for Adult Benefits (Age 19 and Older)

- (1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. An example of an Optional Service is a composite restoration instead of an amalgam restoration on posterior teeth.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means We will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

- (2) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Policy. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.
- (3) We will pay for oral examinations (except after hours exams and exams for observation) and routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) no more than twice in a Calendar Year. See note on additional Benefits during pregnancy.
- (4) A caries risk assessment is allowed once in 12 months.
- (5) Application of caries arresting medicament is limited to twice per tooth per Calendar Year.
- (6) X-ray limitations:
 - a) We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
 - b) When a panoramic film is submitted with supplemental film(s), We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
 - c) If a panoramic film is taken in conjunction with an intraoral complete series, We consider the panoramic film to be included in the complete series.
 - d) A complete intraoral series and panoramic film are each limited to once every 60 months.
 - e) Bitewing x-rays are limited to one (1) time each Calendar Year. Bitewings of any type are not billable to the Enrollee or Delta Dental within six (6) months of a full mouth series.
 - f) Image capture procedures are not separately allowable services.
- (7) Pulp vitality tests are allowed once per day when definitive treatment is not performed.
- (8) Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a 12-month period and included if reported, with any other examination on the same date of service and Provider office.
- (9) We will not cover to replace amalgam and resin-based composite restorations (fillings) and prefabricated restorations within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations, including reattachment of a tooth fragment, within 24 months are included in the fee for the original restoration.

- (10) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- (11) Pin retention is covered not more than once in any 24-month period.
- (12) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.
- (13) The fees for synchronous/asynchronous teledentistry services are considered inclusive in overall patient management and are not separately payable services.

D. Exclusions for Adult Benefits (Age 19 and Older)

We do not pay Benefits for:

- (1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- (2) cosmetic surgery or procedures for purely cosmetic reasons.
- (3) maxillofacial prosthetics.
- (4) provisional and/or temporary restorations.
- (5) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.
- (6) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
- (7) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- (8) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- (9) interim implants.
- (10) indirectly fabricated resin-based Inlays/Onlays.
- (11) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- (12) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- (13) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.
- (14) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

- (15) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- (16) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.
- (17) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.
- (18) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- (19) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric x-rays, oral/facial photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.
- (20) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.
- (21) endodontic endosseous implants.
- (22) services or supplies for sealants, fluoride, space maintainers, apexification and transeptal fiberotomy/supra crestal fiberotomy.
- (23) services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.
- (24) services or supplies for oral surgery, general anesthesia or IV sedation.
- (25) services or supplies for endodontic treatment (procedures for removal of the nerve of the tooth and the treatment of the pulp cavity portion of the root of the tooth).
- (26) services or supplies for periodontic treatment (procedures for the treatment of the gums and the bones supporting teeth).
- (27) services or supplies for denture repairs (repair to partial or complete dentures including rebase procedures and relining).
- (28) services or supplies for crowns and inlays/onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, or plastic restorations.
- (29) services or supplies for prosthodontics (procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges).
- (30) missed and/or cancelled appointments.
- (31) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- (32) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- (33) dental case management motivational interviewing and patient education to improve oral health literacy.
- (34) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

- (35) extra-oral - 2D projection radiographic image and extra-oral posterior dental radiographic image.
- (36) diabetes testing.
- (37) corticotomy (specialized oral surgery procedure associated with orthodontics).
- (38) antigen or antibody testing
- (39) counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

HIPAA Notice of Privacy Practices

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

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

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

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

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

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

PERMITTED USES AND DISCLOSURES OF YOUR PHI

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

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

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

Permitted uses and disclosures without an authorization

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

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

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

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

Disclosures made with your authorization

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

YOUR RIGHTS REGARDING PHI

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

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

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

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

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

You have the right to correct or update your PHI.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMPLAINTS

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

CONTACTS

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

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330

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

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

Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call 1-866-530-9675 (TTY: 711).

¿Puede leer este documento? Si no, podemos encontrar a alguien que lo ayude a leerlo. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 1-866-530-9675 (servicio de retransmisión TTY deben llamar al 711). (Spanish)

您能自行閱讀本文件嗎？如果不能，我們可請人幫助您閱讀。您還可以請人以您的語言撰寫本文件。如需免費幫助，請致電 1-866-530-9675 (TTY: 711)。 (Chinese)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 1-866-530-9675 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수 있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-866-530-9675 (TTY: 711)번으로 연락하십시오. (Korean)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-866-530-9675 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-866-530-9675 (телетайп: 711). (Russian)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نوفر لك من يساعدك في قراءتها. ربما يمكنك أيضًا الحصول على هذا المستند مكتوبًا بلغتك للمساعدة المجانية اتصل بـ 1-866-530-9675 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-866-530-9675 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n'est pas le cas, nous pouvons faire en sorte que quelqu'un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l'assistance gratuitement, veuillez appeler le 1-866-530-9675 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-866-530-9675 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-866-530-9675 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-866-530-9675 (TTY: 711). (Italian)

この文書をお読みになれますか？お読みになれない場合には音読ボランティアを手配させていただきます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、1-866-530-9675 (TTY: 711) までお問い合わせください。 (Japanese)

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 1-866-530-9675 (Schreibtelefon: 711). (German)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخواهیم تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 1-866-530-9675 (TTY: 711). (Persian Farsi)

क्या आप इस दस्तावेज़ को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी सहायता करने हेतु किसी की व्यवस्था कर सकते हैं। आप इस दस्तावेज़ को अपनी भाषा में लिखा हुआ भी प्राप्त कर सकते हैं। निशुल्क सहायता के लिए, कृपया यहाँ कॉल करें 1-866-530-9675 (TTY: 711)। (Hindi)

คุณสามารถอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย ได้รับความช่วยเหลือฟรีได้โดยโทรไปที่ 1-866-530-9675 (TTY: 711) (Thai)

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 ਅਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-866-530-9675 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Դուք կարող եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք կրկն մեկնենք կարգիչներ, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ զրկան ձեր լեզվով: Անվճար օգնություն համար խնդրում ենք զանգահարել 1-866-530-9675 (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 1-866-530-9675 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-866-530-9675 (TTY: 711)។ (Cambodian)

צי קענט איר לייענען דעם דאזיקן דאקומענט? אויב ניט, עמעצער דא קען אייך העלפן אים צו לייענען. עס איז אויך מעגלעך, אז איר קענט באקומען דעם דאזיקן דאקומענט אין אייער שפראך. פֿאַר אומזיסטע הילף קענט איר אַנקלוגען אַ ט די דאזיקע נומער: 1-866-530-9675 אָ איר דאָ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bííníghah? Doo bííníghahgóó éí nich'í' yídóolta'hígíí níhee hólo. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaago ałdó' nich'í' ádoolnǫ́ǫ́go bííghah. T'áá jíík'e shíká i'doolwoł nínízingo kojí' béésh holdíílnih 1-866-530-9675 (TTY: 711) (Navajo)

Non-Discrimination Disclosure

Discrimination is Against the Law

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

ENROLLEE NOTICES

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

Federal Notices:

- **HIPAA Notice of Privacy Practices (NPP):** Federal regulations require insurance plans to share information about the company's privacy practices. This is called a "Notice of Privacy Practices (NPP)" and should be read when an individual first becomes an enrollee and reviewed at least every three years thereafter.
- **Gramm-Leach-Bliley (GLB):** Financial institutions and insurance companies must describe how demographic and financial information is collected and shared. California requires a state specific notice called the California Financial Privacy Notice, which is described below under the State Notices section.
- **Notice of Non-Discrimination:** We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. If you believe we have failed to provide these services or discriminated in another way on the basis of race, color,

national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

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

State Notices:

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



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

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

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PO Box 997330
Sacramento, CA 95899-7330

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