DeltaCare® USA

Alpha Dental of Utah, Inc.
Individual & Family
DeltaCare® USA
Basic Plan for Families

Combined Policy and Disclosure Form

Provided by:

Alpha Dental of Utah, Inc.
(Domiciled in Utah)
257 E 200 South, Suite 850
Salt Lake City, UT 84111

Administered by:

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023-1803
(888) 857-0337
deltadentalins.com

HealthCare.gov
800-318-2596

Policy/Disclosure Form ("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 by Alpha Dental of Utah, Inc. "Company" and administered by Delta Dental Insurance Company ("Delta Dental"). This Policy discloses the terms and conditions of the individual DeltaCare® USA dental plan available in Utah. 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 attachment included with 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.

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

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 Company. 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.

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 Company continues to make this Policy available through the Federally Facilitated Marketplace at the renewal period:

- the Primary Enrollee 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
- the Primary Enrollee 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.

This Policy is signed for 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 DeltaCare USA 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 the dentist on a regular basis.

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

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

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 Company or the Administrator.

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 at 888-857-0337.

If You prefer to write to Us with Your question(s), please mail Your inquiry to the following address:

DeltaCare USA Customer Service

P.O. Box 1803

Alpharetta, GA 30023-1803

Identification Number

Please provide Your identification ("ID") number to Your Dentist whenever You receive dental services. ID cards are not required. If You wish to have an ID card, 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.

Administrator: Delta Dental Insurance Company ("Delta Dental") or other entity designated by Company, operating as an Administrator in the state of Utah. Certain functions described throughout this Policy may be performed by the Administrator, as designated by Company. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023-1803. The Administrator will answer calls directed to 888-857-0337.

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

Authorization: the process by which Company determines if a procedure or treatment is a referable Benefit under Your plan.

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

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

Contract Dentist: a Dentist who provides services in general dentistry and who has agreed to provide Benefits under the plan. Referrals for Special Services must be obtained from Your Contract Dentist

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

Contract Specialist: a Dentist who provides Specialist Services and who has agreed to provide Benefits to You under the plan. Services obtained from a Contract Specialist must be referred by Your Contract Dentist.

Copayment: the amount listed in the Schedules and charged to You by a Contract Dentist or Contract Specialist for the Benefits provided under the plan. Copayments must be paid at the time treatment is received.

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

Effective Date: the 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 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.

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.

Emergency Services: only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing Your health in serious jeopardy.

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."

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.

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.

Optional: any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by You, and is subject to the limitations and exclusions of this Policy.

Out-of-Network: treatment by a Dentist who has not signed an agreement with Company to provide Benefits under the terms of this Policy.

Out-of-Pocket Maximum: the maximum amount that a Pediatric Enrollee must satisfy for Benefits during the Calendar Year. Refer to Schedule A attached to this Policy for details.

Policy: this agreement between Company 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 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.

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.

Premium: the amount payable as provided in the Policy Informarion attachment included with this Policy.

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

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.

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

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.

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 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. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth and payment of the appropriate Premium must be received within 30 days after the date of birth for coverage to continue beyond 30 days. 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.

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, and children as required by a court or administrative order. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth and payment of the appropriate Premium must be received within 30 days after the date of birth for coverage to continue beyond 30 days. 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.

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:

- unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and
- they are chiefly dependent on the Primary Enrollee or Spouse for support; and
- 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 or Spouse for support because of a mental or physical impairment that began before they reach 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 Company continues to make this Policy available through the Federally Facilitated Marketplace at the renewal period:

- the Primary Enrollee 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
- the Primary Enrollee 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

The Primary Enrollee has the right to terminate coverage under this Policy by contacting the Marketplace Call Center. 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 Company 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.

The Primary Enrollee may keep this Policy in force by timely payment of the Premiums. However, Company may terminate coverage due to:

- You are no longer 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;
- Enrollee has reached the age of 19 (coverage will remain in effect through the last day of the month as long as premium has been paid); or
- Company ceasing to renew all Policies issued on this form to residents of the state where You live.

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.

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. For treatment in progress, We will continue to provide Benefits less any applicable Copayment.

Reinstatement

If this Policy is terminated, You may re-enroll in the plan at the next Open Enrollment Period. Any 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")*.

If any renewal Premium is not paid within the Premium grace period the Enrollee for payment, a subsequent acceptance of Premium by Company 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 Company 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 Company has 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 that date. In all other respects You and the Company 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.

What is the DeltaCare USA Plan?

The DeltaCare USA plan provides Pediatric and Adult Benefits through a convenient network of Contract Dentists in the state of Utah. These Dentists are screened to ensure that Our standards of quality, access and safety are maintained. The network is composed of established dental professionals. When You visit Your assigned Contract Dentist, You pay only the applicable Copayment for Benefits. There are no deductibles, lifetime maximums or claim forms.

Benefits, Limitations and Exclusions

This plan provides the Benefits described in the Schedules that are a part of this Policy. Benefits are only available in the state of Utah. The services are performed as deemed appropriate by Your attending Contract Dentist.

Copayments and Other Charges

You are required to pay any Copayments listed in the Schedules attached to this Policy. Copayments are paid directly to the Dentist who provides treatment. Charges for broken appointments and visits after normal visiting hours are listed in the Schedules attached to this Policy.

In the event that We fail to pay a Contract Dentist, You will not be liable to that Dentist for any sums owed by Us. If You have not received Authorization for treatment from an Out-of-Network Dentist, and We fail to pay that Out-of-Network Dentist, You may be liable to that Dentist for the cost of services. For further clarification, see "*Emergency Services"* and *"Specialist Services."*

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

We will provide Contract Dentists at convenient locations during the term of this Policy. Upon enrollment, We will assign You to one Contract Dentist facility. The Policyholder may request changes to the assigned Contract Dentist facility by directing a request to the Customer Service Center at 888-857-0337. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. The change must be requested prior to the 15th of the month to become effective on the first day of the following month.

We will provide You written notice of assignment to another Contract Dentist facility near Your home if: 1) a requested facility is closed to further enrollment; 2) a chosen Contract Dentist facility withdraws from the plan; or 3) an assigned facility requests, for good cause, that You be re-assigned to another facility.

All treatment in progress must be completed before You change to another Contract Dentist facility. For example, this would include: 1) partial or full dentures for which final impressions have been taken; 2) completion of root canals in progress; and 3) delivery of crowns when teeth have been prepared.

All services which are Benefits will be rendered at the Contract Dentist facility assigned to You. Specialist Servies obtained from a Contract Orthodontist or Contract Specialist, must be referred by Your Contract Dentist. We will have no obligation or liability with respect to services rendered by Out-of-Network Dentists, with the exception of Emergency Services or Specialist Services referred by a Contract Dentist, and authorized by Us. All authorized Specialist Services claims will be paid by Us less any applicable Copayments. A Contract Dentist may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services.

If Your assigned Contract Dentist facility terminates participation in the plan, that Contract Dentist facility will complete all treatment in progress as described above.

Emergency Services

The assigned Contract Dentist facility maintains a 24 hour Emergency Services system seven (7) days a week. If Emergency Services are needed, You should contact the Contract Dentist facility whenever possible. If You are unable to reach the Contract Dentist facility for Emergency Services, You should call the Customer Service Center at 888-857-0337 for assistance in obtaining urgent care. During non-business hours or if You require Emergency Services and are 35 miles or more from Your assigned Contract Dentist facility, You do not need to call for referral and may seek treatment from a Dentist other than at the assigned Contract Dentist facility. You are responsible for the Copayment(s) for any treatment received due to an emergency. Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist facility.

Specialist Services

Specialist Services for oral surgery, endodontics, orthodontics, periodontics or pediatric dentistry must be: 1) referred by the assigned Contract Dentist; and 2) authorized by Us. You pay the specified Copayment. (Refer to the Schedules attached to this Policy.)

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

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

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services should be sent to Us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if You can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is Claims Department, P.O. Box 1810, Alpharetta, GA 30023-1810.

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 download a Claim Form from Our website.

Time of Payment

Claims payable under the Policy for any loss other than loss for which the 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.

Processing Policies

The dental care guidelines for the DeltaCare USA plan explains to Contract Dentists what services are covered under this Policy. Contract Dentists, Contract Orthodontists and Contract Specialists will use their professional judgment to determine which services are appropriate for You. Services performed by the Contract Dentists, Contract Orthodontists and Contract Specialists that fall under the scope of Benefits of this Policy are provided subject to any Copayments. If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Us for a determination of whether the proposed treatment is a covered benefit. We will also determine whether the proposed treatment requires treatment by a specialist. An Enrollee may contact Our Customer Service Center at 888-857-0337 for information regarding the dental care guidelines for DeltaCare USA.

ENROLLEE COMPLAINT PROCEDURE

We will provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If You have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or Our operations, or the quality of dental services performed by a Contract Dentist, You may call the Customer Service Center at 888-857-0337, or the complaint may be addressed in writing to:

Quality Management Department

P.O Box 1860

Alpharetta, GA 30023-1860

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

Within 10 business days of the receipt of any complaint, the quality management coordinator will forward to You an acknowledgment of receipt of the complaint. Certain complaints may require that You be referred to a Dentist for clinical evaluation of the dental services provided. We will forward to You a determination, in writing, within 30 days of receipt of a complaint or will provide a written explanation if additional time is required to report on the complaint.

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

If You believe You need further review of Your claim, You may contact the Utah Insurance Department by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by telephone at (801) 538-3077; or electronically at healthappeals.uid@utah.gov.

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 Suite 3110 State Office Building, Salt Lake City, UT 84114; by telephone at (801) 538-3077; or electronically at healthappeals.uid@utah.gov.

PREMIUM PAYMENT RESPONSIBILITIES

Your Premium is determined by the plan design chosen at the time of enrollment and any subsidy You receive, if applicable. Premiums are listed in the Policy Information attachment included with this Policy. The Primary Enrollee is 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 an Enrollee has an Effective Date mid-year due to a Qualifying Status Change or due to other extraordinary circumstance as determined by the Federally Facilitated Marketplace.

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 888-857-0337.

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.

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.

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.

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 protected health information of Enrollees.

Impossibility of Performance

Neither party (Policyholder or Us) 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:

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

If You need these services, contact Our Customer Service Center at 888-857-0337.

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

DeltaCare USA
P.O. Box 997330
Sacramento, CA 95899-7330
Telephone Number: 888-857-0337
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 BY THE 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

Alpha Dental of Utah, Inc.
(Domiciled in Utah)
257 E 200 South, Suite 850
Salt Lake City, Utah 84111

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:

001-00118-0000001-2
Alpha Dental of Utah, Inc.
(Domiciled in Utah)
257 East 200 South, Suite 850
Salt Lake City, UT 84111
deltadentalins.com

SCHEDULE A

Description of Benefits and Copayments
Alpha Dental of Utah, Inc. Individual & Family
DeltaCare® USA
Basic Plan for Families

The Benefits shown below are performed as needed and deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the DeltaCare USA Plan ("Plan"). **Please refer to Schedule B for further clarification of Benefits. Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

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

Out-of-Pocket Maximum ("OOPM") for Pediatric Enrollees (Through Age 18)

Pediatric Enrollee	**$425.00** each Calendar Year
Multiple Pediatric Enrollees	**$850.00** each Calendar Year

OOPM applies only to Essential Health Benefits ("EHB") for Pediatric Enrollee(s). OOPM means the maximum amount of money that a Pediatric Enrollee must pay for Benefits under this plan during a Calendar Year. Payment for Premiums and payment for services that are Optional, that are upgraded treatments, or that are not covered under the Policy, will not count toward the OOPM, and payment for such services will continue to apply even after the OOPM is met.

If more than one Pediatric Enrollee is covered under this Policy, the financial obligation for Benefits is not more than the OOPM for multiple Pediatric Enrollees. After a Pediatric Enrollee meets their Pediatric Enrollee OOPM, they will have no further payment for the remainder of the Calendar Year for Benefits. Once the amount paid by all Pediatric Enrollee(s) equals the OOPM for multiple Pediatric Enrollees, no further payment will be required by any of the Pediatric Enrollee(s) for the remainder of the Calendar Year for Benefits.

Alpha recommends that the Pediatric Enrollee or other party responsible for the Pediatric Enrollee keep a record of payment for Benefits. If you have any questions regarding your OOPM, please contact the Customer Service department at 888-857-0337.

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0100–D0999 I. DIAGNOSTIC					
D0999	Unspecified diagnostic procedure, by report	No cost	$10	*Includes office visit, per visit (in addition to other services)*	*Includes office visit, per visit (in addition to other services)*
D0120	Periodic oral evaluation - established patient	$10	$10	*2 of (D0120, D0150, D0180) per 12 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0140	Limited oral evaluation - problem focused	$10	$10		
D0150	Comprehensive oral evaluation - new or established patient	$10	$10	*2 of (D0120, D0150, D0180) per 12 months*	
D0160	Detailed and extensive oral evaluation - problem focused, by report	Not a benefit	No cost		
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	Not a benefit	No cost		
D0171	Re-evaluation - post-operative office visit	No cost	$10		
D0180	Comprehensive periodontal evaluation - new or established patient	$10	$10	*2 of (D0120, D0150, D0180) per 12 months*	
D0190	Screening of a patient	No cost	No cost	*1 of (D0190, D0191) per 12 months*	*1 of (D0190, D0191) per 12 months*
D0191	Assessment of a patient	No cost	No cost	*1 of (D0190, D0191) per 12 months*	*1 of (D0190, D0191) per 12 months*
D0210	Intraoral - comprehensive series of radiographic images	$10	$10	*1 of (D0210, D0330) per 36 months*	*1 of (D0210 or D0330) per 24 months, or more frequently if medically necessary*
D0220	Intraoral - periapical first radiographic image	$10	$10		
D0230	Intraoral - periapical each additional radiographic image	$10	$10		
D0240	Intraoral - occlusal radiographic image	$10	$10		
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	$10	$10		
D0270	Bitewing - single radiographic image	$10	$10		
D0272	Bitewings - two radiographic images	$10	$10		
D0273	Bitewings - three radiographic images	$10	$10		
D0274	Bitewings - four radiographic images	$10	$10	*2 series per 12 months*	*1 series per 6 months*
D0277	Vertical bitewings - 7 to 8 radiographic images	$10	$10		
D0330	Panoramic radiographic image	$10	$10	*1 of (D0210, D0330) per 36 months*	*1 of (D0210 or D0330) per 24 months, or more frequently if medically necessary*
D0415	Collection of microorganisms for culture and sensitivity	Not a benefit	No cost		
D0419	Assessment of salivary flow by measurement	No cost	No cost	*1 per 12 months*	*1 per 12 months*
D0425	Caries susceptibility tests	Not a benefit	No cost		
D0460	Pulp vitality tests	Not a benefit	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0470	Diagnostic casts	Not a benefit	No cost		
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Not a benefit	No cost		*Available only when performed in conjunction with a covered biopsy*
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not a benefit	No cost		*Available only when performed in conjunction with a covered biopsy*
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Not a benefit	No cost		*Available only when performed in conjunction with a covered biopsy*
D0601	Caries risk assessment and documentation, with a finding of low risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0603	Caries risk assessment and documentation, with a finding of high risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0701	Panoramic radiographic image - image capture only	No cost	No cost		
D0706	Intraoral - occlusal radiographic image - image capture only	No cost	No cost		
D0707	Intraoral - periapical radiographic image - image capture only	No cost	No cost		
D0708	Intraoral - bitewing radiographic image - image capture only	No cost	No cost		
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No cost	No cost		
D1000-D1999 II. PREVENTIVE					
D1110	Prophylaxis - adult	$10	$10	*Cleaning; 2 of (D1110, D1120, D4346) per 12 months; age 14 through 18*	*Cleaning; 2 of (D1110, D4346) per 12 months*
D1110	Prophylaxis - adult	Not a benefit	$45		*Up to 2 additional cleanings per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D1120	Prophylaxis - child	$10	Not a benefit	*Cleaning; 2 of (D1110, D1120, D4346) per 12 months; age 0 to 13*	
D1206	Topical application of fluoride varnish	$10	Not a benefit	*2 of (D1206, D1208) per 12 months*	
D1208	Topical application of fluoride - excluding varnish	$10	Not a benefit	*2 of (D1206, D1208) per 12 months*	
D1310	Nutritional counseling for control of dental disease	Not a benefit	No cost		
D1320	Tobacco counseling for the control and prevention of oral disease	Not a benefit	No cost		
D1330	Oral hygiene instructions	Not a benefit	No cost		
D1351	Sealant - per tooth	$10	Not a benefit	*Permanent molars without restorations or decay through age 18; 1 per tooth per 60 months*	
D1353	Sealant repair - per tooth	$10	Not a benefit	*Permanent molars without restorations or decay through age 18; 1 per tooth per 60 months*	
D1354	Application of caries arresting medicament - per tooth	$10	Not a benefit	*2 per 12 months*	
D2000-D2999 III. RESTORATIVE					
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.					
- Replacement of crowns, inlays and onlays requires the existing restoration to be 60+ months old.					
D2140	Amalgam - one surface, primary or permanent	Not a benefit	$30		
D2150	Amalgam - two surfaces, primary or permanent	Not a benefit	$45		
D2160	Amalgam - three surfaces, primary or permanent	Not a benefit	$55		
D2161	Amalgam - four or more surfaces, primary or permanent	Not a benefit	$60		
D2330	Resin-based composite - one surface, anterior	Not a benefit	$70		
D2331	Resin-based composite - two surfaces, anterior	Not a benefit	$80		
D2332	Resin-based composite - three surfaces, anterior	Not a benefit	$90		
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	Not a benefit	$120		
D2390	Resin-based composite crown, anterior	Not a benefit	$120		
D2391	Resin-based composite - one surface, posterior	Not a benefit	$75		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2392	Resin-based composite - two surfaces, posterior	Not a benefit	$85		
D2393	Resin-based composite - three surfaces, posterior	Not a benefit	$120		
D2394	Resin-based composite - four or more surfaces, posterior	Not a benefit	$125		
D2510	Inlay - metallic - one surface	Not a benefit	$260		*Base metal is the benefit; 1 per 60 months*
D2520	Inlay - metallic - two surfaces	Not a benefit	$270		*Base metal is the benefit; 1 per 60 months*
D2530	Inlay - metallic - three or more surfaces	Not a benefit	$280		*Base metal is the benefit; 1 per 60 months*
D2542	Onlay - metallic - two surfaces	Not a benefit	$270		*Base metal is the benefit; 1 per 60 months*
D2543	Onlay - metallic - three surfaces	Not a benefit	$290		*Base metal is the benefit; 1 per 60 months*
D2544	Onlay - metallic - four or more surfaces	Not a benefit	$300		*Base metal is the benefit; 1 per 60 months*
D2610	Inlay - porcelain/ceramic - one surface	Not a benefit	$325		*1 per 60 months*
D2620	Inlay - porcelain/ceramic - two surfaces	Not a benefit	$335		*1 per 60 months*
D2630	Inlay - porcelain/ceramic - three or more surfaces	Not a benefit	$360		*1 per 60 months*
D2642	Onlay - porcelain/ceramic - two surfaces	Not a benefit	$395		*1 per 60 months*
D2643	Onlay - porcelain/ceramic - three surfaces	Not a benefit	$425		*1 per 60 months*
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not a benefit	$495		*1 per 60 months*
D2650	Inlay - resin-based composite - one surface	Not a benefit	$325		*1 per 60 months*
D2651	Inlay - resin-based composite - two surfaces	Not a benefit	$335		*1 per 60 months*
D2652	Inlay - resin-based composite - three or more surfaces	Not a benefit	$360		*1 per 60 months*
D2662	Onlay - resin-based composite - two surfaces	Not a benefit	$395		*1 per 60 months*
D2663	Onlay - resin-based composite - three surfaces	Not a benefit	$425		*1 per 60 months*
D2664	Onlay - resin-based composite - four or more surfaces	Not a benefit	$495		*1 per 60 months*
D2710	Crown - resin-based composite (indirect)	Not a benefit	$125		*1 per 60 months*
D2712	Crown - 3/4 resin-based composite (indirect)	Not a benefit	$125		*1 per 60 months*
D2720	Crown - resin with high noble metal	Not a benefit	$425		*1 per 60 months*
D2721	Crown - resin with predominantly base metal	Not a benefit	$325		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2722	Crown - resin with noble metal	Not a benefit	$425		*1 per 60 months*
D2740	Crown - porcelain/ceramic	Not a benefit	$495		*1 per 60 months*
D2750	Crown - porcelain fused to high noble metal	Not a benefit	$425		*1 per 60 months*
D2751	Crown - porcelain fused to predominantly base metal	Not a benefit	$325		*1 per 60 months*
D2752	Crown - porcelain fused to noble metal	Not a benefit	$425		*1 per 60 months*
D2753	Crown - porcelain fused to titanium and titanium alloys	Not a benefit	$425		*1 per 60 months*
D2780	Crown - 3/4 cast high noble metal	Not a benefit	$425		*1 per 60 months*
D2781	Crown - 3/4 cast predominantly base metal	Not a benefit	$325		*1 per 60 months*
D2782	Crown - 3/4 cast noble metal	Not a benefit	$425		*1 per 60 months*
D2783	Crown - 3/4 porcelain/ceramic	Not a benefit	$495		*1 per 60 months*
D2790	Crown - full cast high noble metal	Not a benefit	$425		*1 per 60 months*
D2791	Crown - full cast predominantly base metal	Not a benefit	$325		*1 per 60 months*
D2792	Crown - full cast noble metal	Not a benefit	$465		*1 per 60 months*
D2794	Crown - titanium and titanium alloys	Not a benefit	$495		*1 per 60 months*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	Not a benefit	$12		
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	Not a benefit	$12		
D2920	Re-cement or re-bond crown	Not a benefit	$12		
D2921	Reattachment of tooth fragment, incisal edge or cusp	Not a benefit	$75		*Anterior tooth*
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	Not a benefit	$45		
D2931	Prefabricated stainless steel crown - permanent tooth	Not a benefit	$45		
D2932	Prefabricated resin crown	Not a benefit	$85		*Anterior tooth*
D2933	Prefabricated stainless steel crown with resin window	Not a benefit	$125		
D2940	Protective restoration	Not a benefit	$12		
D2949	Restorative foundation for an indirect restoration	Not a benefit	$90		
D2950	Core buildup, including any pins when required	Not a benefit	$90		
D2951	Pin retention - per tooth, in addition to restoration	Not a benefit	$30		
D2952	Post and core in addition to crown, indirectly fabricated	Not a benefit	$85		*Base metal post; includes canal preparation*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2953	Each additional indirectly fabricated post - same tooth	Not a benefit	$50		*Includes canal preparation*
D2954	Prefabricated post and core in addition to crown	Not a benefit	$75		*Includes canal preparation*
D2955	Post removal	Not a benefit	$40		
D2957	Each additional prefabricated post - same tooth	Not a benefit	$45		*Includes canal preparation*
D2960	Labial veneer (resin laminate) - direct	Not a benefit	$315		*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2961	Labial veneer (resin laminate) - indirect	Not a benefit	$365		*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2962	Labial veneer (porcelain laminate) - indirect	Not a benefit	$425		*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	Not a benefit	$65		
D2980	Crown repair necessitated by restorative material failure	Not a benefit	$85		
D2981	Inlay repair necessitated by restorative material failure	Not a benefit	$85		
D2982	Onlay repair necessitated by restorative material failure	Not a benefit	$85		
D2983	Veneer repair necessitated by restorative material failure	Not a benefit	$85		
D3000-D3999 IV. ENDODONTICS					
D3110	Pulp cap - direct (excluding final restoration)	Not a benefit	$18		
D3120	Pulp cap - indirect (excluding final restoration)	Not a benefit	$18		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	Not a benefit	$25		
D3221	Pulpal debridement, primary and permanent teeth	Not a benefit	$80		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	Not a benefit	$240		*Root canal*
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	Not a benefit	$350		*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	Not a benefit	$400		*Root canal*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3331	Treatment of root canal obstruction; non-surgical access	Not a benefit	$165		
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Not a benefit	$165		
D3333	Internal root repair of perforation defects	Not a benefit	$115		
D3346	Retreatment of previous root canal therapy - anterior	Not a benefit	$500		*Per canal*
D3347	Retreatment of previous root canal therapy - premolar	Not a benefit	$600		*Per canal*
D3348	Retreatment of previous root canal therapy - molar	Not a benefit	$725		*Per canal*
D3410	Apicoectomy - anterior	Not a benefit	$85		
D3421	Apicoectomy - premolar (first root)	Not a benefit	$290		
D3425	Apicoectomy - molar (first root)	Not a benefit	$315		
D3426	Apicoectomy (each additional root)	Not a benefit	$85		
D3430	Retrograde filling - per root	Not a benefit	$65		
D3450	Root amputation - per root	Not a benefit	$180		
D3471	Surgical repair of root resorption - anterior	Not a benefit	$85		
D3472	Surgical repair of root resorption - premolar	Not a benefit	$85		
D3473	Surgical repair of root resorption - molar	Not a benefit	$85		
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	Not a benefit	$85		
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	Not a benefit	$85		
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	Not a benefit	$85		
D3911	Intraorifice barrier	Not a benefit	No cost		*Included in case by dentist/dental office who performed Root Canal; a separate charge applies for service provided by a dentist other than the original treating dentist/dental office*
D3920	Hemisection (including any root removal), not including root canal therapy	Not a benefit	$95		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3921	Decoronation or submergence of an erupted tooth	Not a benefit	$45		
D4000-D4999 V. PERIODONTICS					
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.					
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Not a benefit	$200		
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	Not a benefit	$95		
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	Not a benefit	$95		
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Not a benefit	$350		
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	Not a benefit	$280		
D4245	Apically positioned flap	Not a benefit	$280		
D4249	Clinical crown lengthening - hard tissue	Not a benefit	$280		
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	Not a benefit	$650		
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	Not a benefit	$520		
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	Not a benefit	$230		
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	Not a benefit	$120		
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site	Not a benefit	$210		
D4267	Guided tissue regeneration, natural teeth – non-resorbable barrier, per site	Not a benefit	$240		
D4270	Pedicle soft tissue graft procedure	Not a benefit	$290		
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	Not a benefit	$300		
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	Not a benefit	$105		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	Not a benefit	$350		
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	Not a benefit	$245		
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a benefit	$245		
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a benefit	$180		
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a benefit	$210		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	Not a benefit	$116		*1 per quadrant per 24 consecutive months*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	Not a benefit	$69		*1 per quadrant per 24 consecutive months*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$10	$10	*Cleaning; 2 of (D1110, D1120, D4346) per 12 months; age 14 through 18*	*Cleaning; 2 of (D1110, D4346) per 12 months*
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	Not a benefit	$80		*1 treatment per 12 consecutive months*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	Not a benefit	$60		*For each of the first 2 teeth treated within a quadrant following root planing or periodontal maintenance*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	Not a benefit	No cost		*For an additional tooth treated in the same quadrant following root planing or periodontal maintenance*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4910	Periodontal maintenance	Not a benefit	$50		*2 per 12 months*
D4910	Periodontal maintenance	Not a benefit	$70		*Up to 2 additional periodontal maintenances per 12 months*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	Not a benefit	$25		
D4921	Gingival irrigation with a medicinal agent – per quadrant	Not a benefit	No cost		
D5000-D5899 VI. PROSTHODONTICS (removable)					
- For all listed dentures and partial dentures, Copayment includes after delivery adjustments, temporary relining and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments, temporary relining and tissue conditioning, if needed, for the first three months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.					
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.					
- Replacement of a denture or a partial denture requires the existing denture to be 60+ months old.					
D5110	Complete denture - maxillary	Not a benefit	$624		*1 per 60 months*
D5120	Complete denture - mandibular	Not a benefit	$624		*1 per 60 months*
D5130	Immediate denture - maxillary	Not a benefit	$650		*1 per 60 months*
D5140	Immediate denture - mandibular	Not a benefit	$650		*1 per 60 months*
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	Not a benefit	$535		*1 per 60 months*
D5212	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	Not a benefit	$535		*1 per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	Not a benefit	$710		*1 per 60 months*
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	Not a benefit	$710		*1 per 60 months*
D5221	Immediate maxillary partial denture - resin base (including retentive/ clasping materials, rests and teeth)	Not a benefit	$535		*1 per 60 months*
D5222	Immediate mandibular partial denture - resin base (including retentive/ clasping materials, rests, and teeth)	Not a benefit	$535		*1 per 60 months*
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests, and teeth)	Not a benefit	$710		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	Not a benefit	$710		*1 per 60 months*
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not a benefit	$700		*1 per 60 months*
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not a benefit	$700		*1 per 60 months*
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not a benefit	$700		*1 per 60 months*
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not a benefit	$700		*1 per 60 months*
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	Not a benefit	$400		*1 per 60 months*
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	Not a benefit	$400		*1 per 60 months*
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant	Not a benefit	$360		*1 per 60 months*
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant	Not a benefit	$360		*1 per 60 months*
D5410	Adjust complete denture - maxillary	Not a benefit	$24		
D5411	Adjust complete denture - mandibular	Not a benefit	$24		
D5421	Adjust partial denture - maxillary	Not a benefit	$24		
D5422	Adjust partial denture - mandibular	Not a benefit	$24		
D5511	Repair broken complete denture base, mandibular	Not a benefit	$90		
D5512	Repair broken complete denture base, maxillary	Not a benefit	$90		
D5520	Replace missing or broken teeth - complete denture (each tooth)	Not a benefit	$90		
D5611	Repair resin partial denture base, mandibular	Not a benefit	$90		
D5612	Repair resin partial denture base, maxillary	Not a benefit	$90		
D5621	Repair cast partial framework, mandibular	Not a benefit	$90		
D5622	Repair cast partial framework, maxillary	Not a benefit	$90		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5630	Repair or replace broken retentive clasping materials - per tooth	Not a benefit	$75		
D5640	Replace broken teeth - per tooth	Not a benefit	$45		
D5650	Add tooth to existing partial denture	Not a benefit	$60		
D5660	Add clasp to existing partial denture - per tooth	Not a benefit	$75		
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not a benefit	$275		
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not a benefit	$275		
D5710	Rebase complete maxillary denture	Not a benefit	$175		*1 per 12 months*
D5711	Rebase complete mandibular denture	Not a benefit	$175		*1 per 12 months*
D5720	Rebase maxillary partial denture	Not a benefit	$175		*1 per 12 months*
D5721	Rebase mandibular partial denture	Not a benefit	$175		*1 per 12 months*
D5725	Rebase hybrid prosthesis	Not a benefit	$175		*1 per 12 months*
D5730	Reline complete maxillary denture (direct)	Not a benefit	$95		*1 per 12 months*
D5731	Reline complete mandibular denture (direct)	Not a benefit	$95		*1 per 12 months*
D5740	Reline maxillary partial denture (direct)	Not a benefit	$95		*1 per 12 months*
D5741	Reline mandibular partial denture (direct)	Not a benefit	$95		*1 per 12 months*
D5750	Reline complete maxillary denture (indirect)	Not a benefit	$125		*1 per 12 months*
D5751	Reline complete mandibular denture (indirect)	Not a benefit	$125		*1 per 12 months*
D5760	Reline maxillary partial denture (indirect)	Not a benefit	$125		*1 per 12 months*
D5761	Reline mandibular partial denture (indirect)	Not a benefit	$125		*1 per 12 months*
D5765	Soft liner for complete or partial removable denture – indirect	Not a benefit	$125		*1 per 12 months*
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	Not a benefit	$210		*1 per 12 months*
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	Not a benefit	$210		*1 per 12 months*
D5850	Tissue conditioning, maxillary	Not a benefit	$16		*1 per 12 months*
D5851	Tissue conditioning, mandibular	Not a benefit	$16		*1 per 12 months*
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered					
D6000-D6199 VIII. IMPLANT SERVICES - Not Covered					
D6200-D6999 IX. PROSTHODONTICS, fixed					
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge)					
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 60+ months old.					

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6205	Pontic - indirect resin based composite	Not a benefit	$145		*1 per 60 months*
D6210	Pontic - cast high noble metal	Not a benefit	$425		*1 per 60 months*
D6211	Pontic - cast predominantly base metal	Not a benefit	$325		*1 per 60 months*
D6212	Pontic - cast noble metal	Not a benefit	$465		*1 per 60 months*
D6214	Pontic - titanium and titanium alloys	Not a benefit	$495		*1 per 60 months*
D6240	Pontic - porcelain fused to high noble metal	Not a benefit	$425		*1 per 60 months*
D6241	Pontic - porcelain fused to predominantly base metal	Not a benefit	$325		*1 per 60 months*
D6242	Pontic - porcelain fused to noble metal	Not a benefit	$425		*1 per 60 months*
D6243	Pontic - porcelain fused to titanium and titanium alloys	Not a benefit	$425		*1 per 60 months*
D6245	Pontic - porcelain/ceramic	Not a benefit	$495		*1 per 60 months*
D6250	Pontic - resin with high noble metal	Not a benefit	$425		*1 per 60 months*
D6251	Pontic - resin with predominantly base metal	Not a benefit	$325		*1 per 60 months*
D6252	Pontic - resin with noble metal	Not a benefit	$425		*1 per 60 months*
D6600	Retainer inlay - porcelain/ceramic, two surfaces	Not a benefit	$385		*1 per 60 months*
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	Not a benefit	$405		*1 per 60 months*
D6602	Retainer inlay - cast high noble metal, two surfaces	Not a benefit	$370		*1 per 60 months*
D6603	Retainer inlay - cast high noble metal, three or more surfaces	Not a benefit	$380		*1 per 60 months*
D6604	Retainer inlay - cast predominantly base metal, two surfaces	Not a benefit	$270		*1 per 60 months*
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	Not a benefit	$280		*1 per 60 months*
D6606	Retainer inlay - cast noble metal, two surfaces	Not a benefit	$370		*1 per 60 months*
D6607	Retainer inlay - cast noble metal, three or more surfaces	Not a benefit	$380		*1 per 60 months*
D6608	Retainer onlay - porcelain/ceramic, two surfaces	Not a benefit	$395		*1 per 60 months*
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	Not a benefit	$415		*1 per 60 months*
D6610	Retainer onlay - cast high noble metal, two surfaces	Not a benefit	$370		*1 per 60 months*
D6611	Retainer onlay - cast high noble metal, three or more surfaces	Not a benefit	$390		*1 per 60 months*
D6612	Retainer onlay - cast predominantly base metal, two surfaces	Not a benefit	$270		*1 per 60 months*
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	Not a benefit	$290		*1 per 60 months*
D6614	Retainer onlay - cast noble metal, two surfaces	Not a benefit	$370		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6615	Retainer onlay - cast noble metal, three or more surfaces	Not a benefit	$390		*1 per 60 months*
D6710	Retainer crown - indirect resin based composite	Not a benefit	$145		*1 per 60 months*
D6720	Retainer crown - resin with high noble metal	Not a benefit	$425		*1 per 60 months*
D6721	Retainer crown - resin with predominantly base metal	Not a benefit	$325		*1 per 60 months*
D6722	Retainer crown - resin with noble metal	Not a benefit	$425		*1 per 60 months*
D6740	Retainer crown - porcelain/ceramic	Not a benefit	$495		*1 per 60 months*
D6750	Retainer crown - porcelain fused to high noble metal	Not a benefit	$425		*1 per 60 months*
D6751	Retainer crown - porcelain fused to predominantly base metal	Not a benefit	$325		*1 per 60 months*
D6752	Retainer crown - porcelain fused to noble metal	Not a benefit	$425		*1 per 60 months*
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	Not a benefit	$425		*1 per 60 months*
D6780	Retainer crown - 3/4 cast high noble metal	Not a benefit	$425		*1 per 60 months*
D6781	Retainer crown - 3/4 cast predominantly base metal	Not a benefit	$325		*1 per 60 months*
D6782	Retainer crown - 3/4 cast noble metal	Not a benefit	$425		*1 per 60 months*
D6783	Retainer crown - 3/4 porcelain/ceramic	Not a benefit	$495		*1 per 60 months*
D6784	Retainer crown - 3/4 titanium and titanium alloys	Not a benefit	$425		*1 per 60 months*
D6790	Retainer crown - full cast high noble metal	Not a benefit	$425		*1 per 60 months*
D6791	Retainer crown - full cast predominantly base metal	Not a benefit	$325		*1 per 60 months*
D6792	Retainer crown - full cast noble metal	Not a benefit	$465		*1 per 60 months*
D6794	Retainer crown - titanium and titanium alloys	Not a benefit	$495		*1 per 60 months*
D6930	Re-cement or re-bond fixed partial denture	Not a benefit	$12		
D6940	Stress breaker	Not a benefit	$100		
D6980	Fixed partial denture repair necessitated by restorative material failure	Not a benefit	$85		
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY					
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.					
D7111	Extraction, coronal remnants - primary tooth	Not a benefit	$35		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Not a benefit	$45		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Not a benefit	$70		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7220	Removal of impacted tooth - soft tissue	Not a benefit	$100		
D7230	Removal of impacted tooth - partially bony	Not a benefit	$190		
D7240	Removal of impacted tooth - completely bony	Not a benefit	$210		
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	Not a benefit	$230		
D7250	Removal of residual tooth roots (cutting procedure)	Not a benefit	$75		
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	Not a benefit	$230		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Not a benefit	$45		
D7280	Exposure of an unerupted tooth	Not a benefit	$115		
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Not a benefit	$110		
D7283	Placement of device to facilitate eruption of impacted tooth	Not a benefit	No cost		
D7286	Incisional biopsy of oral tissue-soft	Not a benefit	$100		
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Not a benefit	$95		
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	Not a benefit	$95		
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Not a benefit	$125		
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	Not a benefit	$125		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	Not a benefit	$125		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	Not a benefit	$150		
D7471	Removal of lateral exostosis (maxilla or mandible)	Not a benefit	$150		
D7472	Removal of torus palatinus	Not a benefit	$150		
D7473	Removal of torus mandibularis	Not a benefit	$150		
D7510	Incision and drainage of abscess - intraoral soft tissue	Not a benefit	$35		
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Not a benefit	No cost		
D7961	Buccal/labial frenectomy (frenulectomy)	Not a benefit	$160		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7962	Lingual frenectomy (frenulectomy)	Not a benefit	$160		
D7970	Excision of hyperplastic tissue - per arch	Not a benefit	$115		
D7971	Excision of pericoronal gingiva	Not a benefit	$115		
D8000-D8999 XI. ORTHODONTICS - Adult Enrollee Benefits					
- Including covered dependent adult children. The Enrollee must continue to be eligible during active treatment.					
- The listed Copayment for each phase of orthodontic treatment (limited or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.					
- The Retention Copayment includes adjustments and/or office visits up to 24 months.					
Pre and post orthodontic records include:					
The benefit for pre-treatment records and diagnostic services includes:		Not a benefit	$250		
D0210	Intraoral - comprehensive series of radiographic images	Not a benefit	Included		
D0322	Tomographic survey	Not a benefit	Included		
D0330	Panoramic radiographic image	Not a benefit	Included		
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	Not a benefit	Included		
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	Not a benefit	Included		
D0351	3D photographic image	Not a benefit	Included		
D0470	Diagnostic casts	Not a benefit	Included		
D0701	Panoramic radiographic image - image capture only	Not a benefit	Included		
D0702	2D cephalometric radiographic image - image capture only	Not a benefit	Included		
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	Not a benefit	Included		
D0704	3D photographic image - image capture only	Not a benefit	Included		
D0709	Intraoral - comprehensive series of radiographic images - image capture only	Not a benefit	Included		
The benefit for post-treatment records includes:		Not a benefit	$70		
D0210	Intraoral - comprehensive series of radiographic images	Not a benefit	Included		
D0470	Diagnostic casts	Not a benefit	Included		
D0709	Intraoral - comprehensive series of radiographic images - image capture only	Not a benefit	Included		
D8040	Limited orthodontic treatment of the adult dentition	Not a benefit	$1,950		
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Not a benefit	$3,250		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8090	Comprehensive orthodontic treatment of the adult dentition	Not a benefit	$3,250		
D8660	Pre-orthodontic treatment examination to monitor growth and development	Not a benefit	$25		*1 per 6 months when performed by the same Contract Dentist or dental office*
D8670	Periodic orthodontic treatment visit	Not a benefit	No cost		*Included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Not a benefit	$450		*Placement of removable retainers*
D8681	Removable orthodontic retainer adjustment	Not a benefit	No cost		
D8698	Re-cement or re-bond fixed retainer - maxillary	Not a benefit	No cost		*2 per 6 months*
D8699	Re-cement or re-bond fixed retainer - mandibular	Not a benefit	No cost		*2 per 6 months*
D8701	Repair of fixed retainer, includes reattachment - maxillary	Not a benefit	No cost		*2 per 6 months*
D8702	Repair of fixed retainer, includes reattachment - mandibular	Not a benefit	No cost		*2 per 6 months*
D8999	Unspecified orthodontic procedure, by report	Not a benefit	$250		*Includes treatment planning session*
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES					
D9110	Palliative treatment of dental pain - per visit	$45	$35		
D9211	Regional block anesthesia	Not a benefit	No cost		
D9212	Trigeminal division block anesthesia	Not a benefit	No cost		
D9215	Local anesthesia in conjunction with operative or surgical procedures	Not a benefit	No cost		
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	Not a benefit	$10		
D9222	Deep sedation/general anesthesia - first 15 minutes	Not a benefit	$55		*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	Not a benefit	$55		*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	Not a benefit	$55		*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	Not a benefit	$55		*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Not a benefit	$10		
D9311	Consultation with a medical health care professional	No cost	No cost		
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	Not a benefit	$10		
D9440	Office visit - after regularly scheduled hours	Not a benefit	$40		
D9450	Case presentation, subsequent to detailed and extensive treatment planning	Not a benefit	No cost		
D9912	Pre-visit patient screening	No cost	No cost		
D9932	Cleaning and inspection of removable complete denture, maxillary	Not a benefit	$10		
D9933	Cleaning and inspection of removable complete denture, mandibular	Not a benefit	$10		
D9934	Cleaning and inspection of removable partial denture, maxillary	Not a benefit	$10		
D9935	Cleaning and inspection of removable partial denture, mandibular	Not a benefit	$10		
D9943	Occlusal guard adjustment	Not a benefit	$24		*1 per 12 months (6 months after initial placement)*
D9944	Occlusal guard - hard appliance, full arch	Not a benefit	$175		*1 of (D9944, D9945, D9946) per 36 months*
D9945	Occlusal guard - soft appliance, full arch	Not a benefit	$45		*1 of (D9944, D9945, D9946) per 36 months*
D9946	Occlusal guard - hard appliance, partial arch	Not a benefit	$90		*1 of (D9944, D9945, D9946) per 36 months*
D9951	Occlusal adjustment - limited	Not a benefit	$40		
D9952	Occlusal adjustment - complete	Not a benefit	$90		*1 per 36 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	Not a benefit	$125		*Limited to 1 bleaching tray and gel for 2 weeks of self treatment*
D9986	Missed appointment	Not a benefit	$50		*Without 24 hour notice*
D9987	Cancelled appointment	Not a benefit	$50		*Without 24 hour notice*
D9991	Dental case management - addressing appointment compliance barriers	No cost	No cost		
D9992	Dental case management - care coordination	No cost	No cost		
D9995	Teledentistry - synchronous; real-time encounter	No cost	No cost		
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No cost	No cost		
D9997	Dental case management - patients with special health care needs	Not a benefit	No cost		

Endnotes:

Unless clarified elsewhere in the Schedule A, base metal is the Benefit. If noble or high noble metal (precious) is used for an implant/abutment supported crown, or fixed bridge retainer, indirectly fabricated post and core, inlay or onlay, the Enrollee will be charged the additional laboratory cost of the noble or high noble metal. If covered, an additional laboratory charge also applies to a titanium crown.

Porcelain/ceramic crown, pontic and fixed bridge retainer on molars is considered a material upgrade with a maximum additional charge to the Enrollee of $150 per unit.

When there are more than six crowns, retainers and/or pontics in the same treatment plan, an Enrollee may be charged an additional $125 per unit, beyond the 6th unit.

Name brand, laboratory processed, or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325 in addition to the listed Copayment. Refer to *Schedule B for Limitations and Exclusions* for additional information.

If services for a listed procedure are performed by the Contract Dentist, the Enrollee pays the specified Copayment(s). Listed procedures which require a Dentist to provide Specialist Services, and are referred by the Contract Dentist, must be authorized by this Plan. The Enrollee pays the Copayment(s) specified for such services.

Optional or upgraded procedure(s) are defined as any alternative procedure(s) presented by the Contract Dentist and formally agreed upon by financial consent that satisfies the same dental need as a covered procedure. Enrollee may elect an optional or upgraded procedure, subject to the limitations and exclusions of this Plan. The applicable charge to the Enrollee is the difference between the Contract Dentist's regularly charged fee (or contracted fee, when applicable) for the Optional or upgraded procedure and the covered procedure, plus any applicable copayment for the covered procedure.

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SCHEDULE B
Limitations and Exclusions of Benefits
Alpha Dental of Utah, Inc. Individual & Family
DeltaCare® USA
Preferred Plan for Families/Basic Plan for Families

Limitations and Exclusions of Benefits for Adults (Age 19 and Older)

Limitations of Benefits for Adult Enrollees

1. The frequency of certain Benefits is limited. Frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*

2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $125.00 above the listed Copayment for each of these services after the sixth unit has been provided.

3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions (Procedures D7230, D7240, and D7241).

4. Name brand, laboratory processed, or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan benefits of a high-quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Contact the Customer Service department at 888-857-0337 if you have questions regarding the additional fee or name brand services.

5. Benefits provided by a pediatric Dentist are limited to children through age thirteen following an attempt by the assigned Contract Dentist to treat the child and upon prior Authorization by the plan, less applicable Copayments. The plan will consider exceptions on an individual basis if a child has a physical or mental impairment, limitation or condition which substantially interferes with that child's ability to have Benefits provided by a Contract Dentist.

6. Benefits for a soft tissue management program are limited to those parts which are listed covered services listed on *Schedule A, Description of Benefits and Copayments*. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered Benefits.

7. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's submitted fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.

Exception to extend covered orthodontics Benefits to a cancelled or terminated Contract is as follows:

a. For 60 days after the date coverage terminates if the Contract Orthodontist has agreed to or is receiving monthly payments; or

b. Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Contract Orthodontist has agreed to accept or is receiving payments on a quarterly basis.

8. All orthodontic services, including direct to consumer orthodontics, must be provided by a licensed Dentist authorized to deliver care in Your state. Claims for services that are not provided by a Dentist are not eligible for reimbursement.

Exclusions of Benefits for Adult Enrollees

1. Any procedure that is not specifically listed as a covered Benefit under *Schedule A*, *Description of Benefits and Copayments*.

2. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures or is inconsistent with generally accepted standards for dentistry.

3. Services solely for cosmetic purposes, with the exception of procedure D9975 (external bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.

4. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges).

5. Lost, stolen, or broken appliances including, but not limited to, full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges), orthodontic and other appliances.

6. Procedures, appliances, or restoration if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), with the exception of procedures as shown on *Schedule A, Description of Benefits and Copayments.*

7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.

8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal, and all other services associated with a dental implant.

9. Consultations or other diagnostic services for non-covered Benefits.

10. Dental services received from any dental facility other than the assigned Contract Dentist or an authorized dental specialist (oral surgeon, endodontist, periodontist, pediatric dentist, or Contract Orthodontist) except for *Emergency Dental Services* as described in the Policy.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

12. Prescription and over-the-counter drugs.

13. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision

14. Changes in orthodontic treatment necessitated by accident of any kind.

15. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures as shown on *Schedule A, Description of Benefits and Copayments*.

16. Composite or ceramic brackets, or lingual adaptation of orthodontic bands.

17. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

18. Orthodontics, including oral evaluations and all treatment, must be performed by a licensed dentist or his or her supervised staff, acting within the scope of applicable law. The dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan.

19. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.

Limitations and Exclusions of Essential Health Benefits for Pediatric Enrollees (Through Age 18)

<u>Limitations of Benefits for Pediatric Enrollees</u>

1. Diagnostic Benefits are limited as follows:

    a) Two oral evaluations (D0120, D0150 and D0180) are covered in a 12 consecutive month period. A re-evaluation is considered included in the primary procedure and is not payable separately.

    b) Comprehensive mouth images (posterior bitewing images and 14 periapical images plus bitewings) in conjunction with periodic examinations are limited once every thirty-six (36) consecutive months; in lieu of panoramic image.

    c) Bitewing images in conjunction with periodic examinations are limited to two (2) series of four (4) images in any twelve (12) consecutive month period.

    d) Panoramic image (D0330) is limited to once every thirty-six (36) consecutive months; in lieu of comprehensive mouth images.

    e) Vertical bitewings (D0277) are limited up to eight images.

2. Preventive Benefits are limited as follows:

    a) Two routine prophylaxes (cleanings) (D1110, D1120) are covered in a 12 consecutive month period.

    b) A child prophylaxis (D1120) will be covered through age 13.

    c) An adult prophylaxis (D1110) will be covered for age 14 through 18.

d) Two fluoride applications (D1206, D1208) are covered in a 12 consecutive month period.

e) Sealants (D1351) are only covered on permanent molars without restorations or decay. One sealant per tooth is limited to once every sixty (60) consecutive month period.

f) Sealants are not covered if there is an existing restoration (filling) that involves the biting surface of the tooth or if such a restoration is placed at the same time as the sealant.

Exclusions of Benefits for Pediatric Enrollees

The following dental services are excluded under the plan:

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.

2. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures or is inconsistent with generally accepted standards for dentistry.

3. Consultations or other diagnostic services for non-covered Benefits.

4. Dental services received from any dental facility other than the assigned Contract Dentist or a preauthorized dental specialist except for *Emergency Services* as described in the Policy.

5. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

6. Prescription and over-the-counter drugs.

7. Dental conditions arising out of and due to an Enrollee's employment for which Worker's Compensation or an Employer's Liability Law is payable. The participating dental plan will provide the services at the time of need and the Enrollee will cooperate to ensure that the participating dental plan is reimbursed for such Benefits.

8. Services which were provided without cost to the Enrollee by the State government or an agency thereof, or any municipality, county or other subdivisions.

9. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Enrollee became eligible with the DeltaCare USA plan for such services.

10. Services and supplies for sleep apnea.

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DeltaCare® USA
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 Alpha Dental of Utah, Inc. 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.

Description of Benefits and Copayments
Alpha Dental of Utah, Inc. Individual & Family
DeltaCare® USA
Basic Plan for Families

The Benefits shown below are performed as needed and deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the DeltaCare USA Plan ("Plan"). **Please refer to Schedule B for further clarification of Benefits. Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

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

Out-of-Pocket Maximum ("OOPM") for Pediatric Enrollees (Through Age 18)

Pediatric Enrollee	**$425** each Calendar Year
Multiple Pediatric Enrollees	**$850** each Calendar Year

OOPM applies only to Essential Health Benefits ("EHB") for Pediatric Enrollee(s). OOPM means the maximum amount of money that a Pediatric Enrollee must pay for Benefits under this plan during a Calendar Year. Payment for Premiums and payment for services that are Optional, that are upgraded treatments or that are not covered under the Policy will not count toward the OOPM, and payment for such services will continue to apply even after the OOPM is met.

If more than one Pediatric Enrollee is covered under this Policy, the financial obligation for Benefits is not more than the OOPM for multiple Pediatric Enrollees. After a Pediatric Enrollee meets their Pediatric Enrollee OOPM, they will have no further payment for the remainder of the Calendar Year for Benefits. Once the amount paid by all Pediatric Enrollee(s) equals the OOPM for multiple Pediatric Enrollees, no further payment will be required by any of the Pediatric Enrollee(s) for the remainder of the Calendar Year for Benefits.

Alpha recommends that the Pediatric Enrollee or other party responsible for the Pediatric Enrollee keep a record of payment for Benefits. If you have any questions regarding your OOPM, please contact the Customer Service department at 888-857-0337.

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0100–D0999 I. DIAGNOSTIC					
D0999	Unspecified diagnostic procedure, by report	No cost	$10	*Includes office visit, per visit (in addition to other services)*	*Includes office visit, per visit (in addition to other services)*
D0120	Periodic oral evaluation - established patient	$10	$10	*2 of (D0120, D0150, D0180) per 12 months*	
D0140	Limited oral evaluation - problem focused	$10	$10		
D0150	Comprehensive oral evaluation - new or established patient	$10	$10	*2 of (D0120, D0150, D0180) per 12 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0160	Detailed and extensive oral evaluation - problem focused, by report	Not a benefit	No cost		
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	Not a benefit	No cost		
D0171	Re-evaluation - post-operative office visit	No cost	$10		
D0180	Comprehensive periodontal evaluation - new or established patient	$10	$10	*2 of (D0120, D0150, D0180) per 12 months*	
D0190	Screening of a patient	No Cost	No cost	*1 of (D0190, D0191) per 12 months*	*1 of (D0190, D0191) per 12 months*
D0191	Assessment of a patient	No Cost	No cost	*1 of (D0190, D0191) per 12 months*	*1 of (D0190, D0191) per 12 months*
D0210	Intraoral - comprehensive series of radiographic images	$10	$10	*1 of (D0210, D0330) per 36 months*	*1 of (D0210, D0330) per 24 months*
D0220	Intraoral - periapical first radiographic image	$10	$10		
D0230	Intraoral - periapical each additional radiographic image	$10	$10		
D0240	Intraoral - occlusal radiographic image	$10	$10		
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	$10	$10		
D0270	Bitewing - single radiographic image	$10	$10		
D0272	Bitewings - two radiographic images	$10	$10		
D0273	Bitewings - three radiographic images	$10	$10		
D0274	Bitewings - four radiographic images	$10	$10	*2 series per 12 months*	*1 series per 6 months*
D0277	Vertical bitewings - 7 to 8 radiographic images	$10	$10		
D0330	Panoramic radiographic image	$10	$10	*1 of (D0210, D0330) per 36 months*	*1 of (D0210, D0330) per 24 months*
D0415	Collection of microorganisms for culture and sensitivity	Not a benefit	No cost		
D0419	Assessment of salivary flow by measurement	No cost	No cost	*1 per 12 months*	*1 per 12 months*
D0425	Caries susceptibility tests	Not a benefit	No cost		
D0460	Pulp vitality tests	Not a benefit	No cost		
D0470	Diagnostic casts	Not a benefit	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Not a benefit	No cost		*Available only when performed in conjunction with a covered biopsy*
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not a benefit	No cost		*Available only when performed in conjunction with a covered biopsy*
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Not a benefit	No cost		*Available only when performed in conjunction with a covered biopsy*
D0601	Caries risk assessment and documentation, with a finding of low risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0603	Caries risk assessment and documentation, with a finding of high risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0701	Panoramic radiographic image - image capture only	No cost	No cost		
D0706	Intraoral - occlusal radiographic image - image capture only	No cost	No cost		
D0707	Intraoral - periapical radiographic image - image capture only	No cost	No cost		
D0708	Intraoral - bitewing radiographic image - image capture only	No cost	No cost		
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No cost	No cost		
D1000-D1999 II. PREVENTIVE					
D1110	Prophylaxis - adult	$10	$10	*Cleaning; 2 of (D1110, D1120, D4346) per 12 months; age 14 through 18*	*Cleaning; 2 of (D1110, D4346) per 12 months*
D1110	Prophylaxis - adult	Not a benefit	$45		*Up to 2 additional cleanings per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D1120	Prophylaxis - child	$10	Not a benefit	*Cleaning; 2 of (D1110, D1120, D4346) per 12 months; age 0 to 13*	
D1206	Topical application of fluoride varnish	$10	Not a benefit	*2 of (D1206, D1208) per 12 months*	
D1208	Topical application of fluoride - excluding varnish	$10	Not a benefit	*2 of (D1206, D1208) per 12 months*	
D1310	Nutritional counseling for control of dental disease	Not a benefit	No cost		
D1320	Tobacco counseling for the control and prevention of oral disease	Not a benefit	No cost		
D1330	Oral hygiene instructions	Not a benefit	No cost		
D1351	Sealant - per tooth	$10	Not a benefit	*Permanent molars without restorations or decay through age 18; 1 per tooth per 60 months*	
D1353	Sealant repair - per tooth	$10	Not a benefit	*Permanent molars without restorations or decay through age 18; 1 per tooth per 60 months*	
D1354	Application of caries arresting medicament - per tooth	$10	Not a benefit	*2 per 12 months*	
D2000-D2999 III. RESTORATIVE					
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.					
- Replacement of crowns, inlays and onlays requires the existing restoration to be 60+ months old.					
D2140	Amalgam - one surface, primary or permanent	Not a benefit	$30		
D2150	Amalgam - two surfaces, primary or permanent	Not a benefit	$45		
D2160	Amalgam - three surfaces, primary or permanent	Not a benefit	$55		
D2161	Amalgam - four or more surfaces, primary or permanent	Not a benefit	$60		
D2330	Resin-based composite - one surface, anterior	Not a benefit	$70		
D2331	Resin-based composite - two surfaces, anterior	Not a benefit	$80		
D2332	Resin-based composite - three surfaces, anterior	Not a benefit	$90		
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	Not a benefit	$120		
D2390	Resin-based composite crown, anterior	Not a benefit	$120		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2391	Resin-based composite - one surface, posterior	Not a benefit	$75		
D2392	Resin-based composite - two surfaces, posterior	Not a benefit	$85		
D2393	Resin-based composite - three surfaces, posterior	Not a benefit	$120		
D2394	Resin-based composite - four or more surfaces, posterior	Not a benefit	$125		
D2510	Inlay - metallic - one surface	Not a benefit	$260		*Base metal is the benefit; 1 per 60 months*
D2520	Inlay - metallic - two surfaces	Not a benefit	$270		*Base metal is the benefit; 1 per 60 months*
D2530	Inlay - metallic - three or more surfaces	Not a benefit	$280		*Base metal is the benefit; 1 per 60 months*
D2542	Onlay - metallic - two surfaces	Not a benefit	$270		*Base metal is the benefit; 1 per 60 months*
D2543	Onlay - metallic - three surfaces	Not a benefit	$290		*Base metal is the benefit; 1 per 60 months*
D2544	Onlay - metallic - four or more surfaces	Not a benefit	$300		*Base metal is the benefit; 1 per 60 months*
D2610	Inlay - porcelain/ceramic - one surface	Not a benefit	$325		*1 per 60 months*
D2620	Inlay - porcelain/ceramic - two surfaces	Not a benefit	$335		*1 per 60 months*
D2630	Inlay - porcelain/ceramic - three or more surfaces	Not a benefit	$360		*1 per 60 months*
D2642	Onlay - porcelain/ceramic - two surfaces	Not a benefit	$395		*1 per 60 months*
D2643	Onlay - porcelain/ceramic - three surfaces	Not a benefit	$425		*1 per 60 months*
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not a benefit	$495		*1 per 60 months*
D2650	Inlay - resin-based composite - one surface	Not a benefit	$325		*1 per 60 months*
D2651	Inlay - resin-based composite - two surfaces	Not a benefit	$335		*1 per 60 months*
D2652	Inlay - resin-based composite - three or more surfaces	Not a benefit	$360		*1 per 60 months*
D2662	Onlay - resin-based composite - two surfaces	Not a benefit	$395		*1 per 60 months*
D2663	Onlay - resin-based composite - three surfaces	Not a benefit	$425		*1 per 60 months*
D2664	Onlay - resin-based composite - four or more surfaces	Not a benefit	$495		*1 per 60 months*
D2710	Crown - resin-based composite (indirect)	Not a benefit	$125		*1 per 60 months*
D2712	Crown - 3/4 resin-based composite (indirect)	Not a benefit	$125		*1 per 60 months*
D2720	Crown - resin with high noble metal	Not a benefit	$425		*1 per 60 months*
D2721	Crown - resin with predominantly base metal	Not a benefit	$325		*1 per 60 months*
D2722	Crown - resin with noble metal	Not a benefit	$425		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2740	Crown - porcelain/ceramic	Not a benefit	$495		*1 per 60 months*
D2750	Crown - porcelain fused to high noble metal	Not a benefit	$425		*1 per 60 months*
D2751	Crown - porcelain fused to predominantly base metal	Not a benefit	$325		*1 per 60 months*
D2752	Crown - porcelain fused to noble metal	Not a benefit	$425		*1 per 60 months*
D2753	Crown - porcelain fused to titanium and titanium alloys	Not a benefit	$425		*1 per 60 months*
D2780	Crown - 3/4 cast high noble metal	Not a benefit	$425		*1 per 60 months*
D2781	Crown - 3/4 cast predominantly base metal	Not a benefit	$325		*1 per 60 months*
D2782	Crown - 3/4 cast noble metal	Not a benefit	$425		*1 per 60 months*
D2783	Crown - 3/4 porcelain/ceramic	Not a benefit	$495		*1 per 60 months*
D2790	Crown - full cast high noble metal	Not a benefit	$425		*1 per 60 months*
D2791	Crown - full cast predominantly base metal	Not a benefit	$325		*1 per 60 months*
D2792	Crown - full cast noble metal	Not a benefit	$465		*1 per 60 months*
D2794	Crown - titanium and titanium alloys	Not a benefit	$495		*1 per 60 months*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	Not a benefit	$12		
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	Not a benefit	$12		
D2920	Re-cement or re-bond crown	Not a benefit	$12		
D2921	Reattachment of tooth fragment, incisal edge or cusp	Not a benefit	$75		*Anterior tooth*
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	Not a benefit	$45		
D2931	Prefabricated stainless steel crown - permanent tooth	Not a benefit	$45		
D2932	Prefabricated resin crown	Not a benefit	$85		*Anterior tooth*
D2933	Prefabricated stainless steel crown with resin window	Not a benefit	$125		
D2940	Protective restoration	Not a benefit	$12		
D2949	Restorative foundation for an indirect restoration	Not a benefit	$90		
D2950	Core buildup, including any pins when required	Not a benefit	$90		
D2951	Pin retention - per tooth, in addition to restoration	Not a benefit	$30		
D2952	Post and core in addition to crown, indirectly fabricated	Not a benefit	$85		*Base metal post; includes canal preparation*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2953	Each additional indirectly fabricated post - same tooth	Not a benefit	$50		*Includes canal preparation*
D2954	Prefabricated post and core in addition to crown	Not a benefit	$75		*Includes canal preparation*
D2955	Post removal	Not a benefit	$40		
D2957	Each additional prefabricated post - same tooth	Not a benefit	$45		*Includes canal preparation*
D2960	Labial veneer (resin laminate) - direct	Not a benefit	$315		*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2961	Labial veneer (resin laminate) - indirect	Not a benefit	$365		*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2962	Labial veneer (porcelain laminate) - laboratory	Not a benefit	$425		*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	Not a benefit	$65		
D2980	Crown repair necessitated by restorative material failure	Not a benefit	$85		
D2981	Inlay repair necessitated by restorative material failure	Not a benefit	$85		
D2982	Onlay repair necessitated by restorative material failure	Not a benefit	$85		
D2983	Veneer repair necessitated by restorative material failure	Not a benefit	$85		
D3000-D3999 IV. ENDODONTICS					
D3110	Pulp cap - direct (excluding final restoration)	Not a benefit	$18		
D3120	Pulp cap - indirect (excluding final restoration)	Not a benefit	$18		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	Not a benefit	$25		
D3221	Pulpal debridement, primary and permanent teeth	Not a benefit	$80		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	Not a benefit	$240		*Root canal*
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	Not a benefit	$350		*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	Not a benefit	$400		*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	Not a benefit	$165		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Not a benefit	$165		
D3333	Internal root repair of perforation defects	Not a benefit	$115		
D3346	Retreatment of previous root canal therapy - anterior	Not a benefit	$500		*Per canal*
D3348	Retreatment of previous root canal therapy - molar	Not a benefit	$725		*Per canal*
D3410	Apicoectomy - anterior	Not a benefit	$85		
D3421	Apicoectomy - premolar (first root)	Not a benefit	$290		
D3425	Apicoectomy - molar (first root)	Not a benefit	$315		
D3426	Apicoectomy (each additional root)	Not a benefit	$85		
D3427	Periradicular surgery without apicoectomy	Not a benefit	$85		
D3430	Retrograde filling - per root	Not a benefit	$65		
D3450	Root amputation - per root	Not a benefit	$180		
D3471	Surgical repair of root resorption - anterior	Not a benefit	$85		
D3472	Surgical repair of root resorption - premolar	Not a benefit	$85		
D3473	Surgical repair of root resorption - molar	Not a benefit	$85		
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	Not a benefit	$85		
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	Not a benefit	$85		
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	Not a benefit	$85		
D3911	Intraorifice barrier	Not a benefit	No cost		*Included in case by dentist/dental office who performed Root Canal; a separate charge applies for service provided by a dentist other than the original treating dentist/dental office*
D3920	Hemisection (including any root removal), not including root canal therapy	Not a benefit	$95		
D3921	Decoronation or submergence of an erupted tooth	Not a benefit	$45		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4000-D4999 V. PERIODONTICS					
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.					
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Not a benefit	$200		
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	Not a benefit	$95		
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	Not a benefit	$95		
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Not a benefit	$350		
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	Not a benefit	$280		
D4245	Apically positioned flap	Not a benefit	$280		
D4249	Clinical crown lengthening - hard tissue	Not a benefit	$280		
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	Not a benefit	$650		
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	Not a benefit	$520		
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	Not a benefit	$230		
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	Not a benefit	$120		
D4266	Guided tissue regeneration, natural teeth,resorbable barrier, per site	Not a benefit	$210		
D4267	Guided tissue regeneration, natural teeth,nonresorbable barrier, per site	Not a benefit	$240		
D4270	Pedicle soft tissue graft procedure	Not a benefit	$290		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	Not a benefit	$300		
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	Not a benefit	$105		
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	Not a benefit	$350		
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	Not a benefit	$245		
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a benefit	$245		
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a benefit	$180		
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a benefit	$210		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	Not a benefit	$116		*1 per quadrant per 24 consecutive months*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	Not a benefit	$69		*1 per quadrant per 24 consecutive months*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$10	$10	*Cleaning; 2 of (D1110, D1120, D4346) per 12 months; age 14 through 18*	*Cleaning; 2 of (D1110, D4346) per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	Not a benefit	$80		*1 treatment per 12 consecutive months*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	Not a benefit	$60		*For each of the first 2 teeth treated within a quadrant following root planing or periodontal maintenance*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	Not a benefit	No cost		*For an additional tooth treated in the same quadrant following root planing or periodontal maintenance*
D4910	Periodontal maintenance	Not a benefit	$50		*2 per 12 months*
D4910	Periodontal maintenance	Not a benefit	$70		*Up to 2 additional periodontal maintenances per 12 months*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	Not a benefit	$25		
D4921	Gingival irrigation with a medical agent- per quadrant	Not a benefit	No cost		
D5000-D5899 VI. PROSTHODONTICS (removable)					
- For all listed dentures and partial dentures, Copayment includes after delivery adjustments, temporary relining and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments, temporary relining and tissue conditioning, if needed, for the first three months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.					
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.					
- Replacement of a denture or a partial denture requires the existing denture to be 60+ months old.					
D5110	Complete denture - maxillary	Not a benefit	$624		*1 per 60 months*
D5120	Complete denture - mandibular	Not a benefit	$624		*1 per 60 months*
D5130	Immediate denture - maxillary	Not a benefit	$650		*1 per 60 months*
D5140	Immediate denture - mandibular	Not a benefit	$650		*1 per 60 months*
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	Not a benefit	$535		*1 per 60 months*
D5212	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	Not a benefit	$535		*1 per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Not a benefit	$710		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Not a benefit	$710		*1 per 60 months*
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	Not a benefit	$535		*1 per 60 months*
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	Not a benefit	$535		*1 per 60 months*
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Not a benefit	$710		*1 per 60 months*
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Not a benefit	$710		*1 per 60 months*
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not a benefit	$700		*1 per 60 months*
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not a benefit	$700		*1 per 60 months*
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not a benefit	$700		*1 per 60 months*
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not a benefit	$700		*1 per 60 months*
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests,and teeth), maxillary	Not a benefit	$400		*1 per 60 months*
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests,and teeth), mandibular	Not a benefit	$400		*1 per 60 months*
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests,and teeth) - per quadrant	Not a benefit	$360		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests,and teeth) - per quadrant	Not a benefit	$360		*1 per 60 months*
D5410	Adjust complete denture - maxillary	Not a benefit	$24		
D5411	Adjust complete denture - mandibular	Not a benefit	$24		
D5421	Adjust partial denture - maxillary	Not a benefit	$24		
D5422	Adjust partial denture - mandibular	Not a benefit	$24		
D5511	Repair broken complete denture base, mandibular	Not a benefit	$90		
D5512	Repair broken complete denture base, maxillary	Not a benefit	$90		
D5520	Replace missing or broken teeth - complete denture (each tooth)	Not a benefit	$90		
D5611	Repair resin partial denture base, mandibular	Not a benefit	$90		
D5612	Repair resin partial denture base, maxillary	Not a benefit	$90		
D5621	Repair cast partial framework, mandibular	Not a benefit	$90		
D5622	Repair cast partial framework, maxillary	Not a benefit	$90		
D5630	Repair or replace broken retentive clasping materials - per tooth	Not a benefit	$75		
D5640	Replace broken teeth - per tooth	Not a benefit	$45		
D5650	Add tooth to existing partial denture	Not a benefit	$60		
D5660	Add clasp to existing partial denture - per tooth	Not a benefit	$75		
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not a benefit	$275		
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not a benefit	$275		
D5710	Rebase complete maxillary denture	Not a benefit	$175		*1 per 12 months*
D5711	Rebase complete mandibular denture	Not a benefit	$175		*1 per 12 months*
D5720	Rebase maxillary partial denture	Not a benefit	$175		*1 per 12 months*
D5721	Rebase mandibular partial denture	Not a benefit	$175		*1 per 12 months*
D5725	Rebase hybrid prosthesis	Not a benefit	$175		*1 per 12 months*
D5730	Reline complete maxillary denture (direct)	Not a benefit	$95		*1 per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5731	Reline complete mandibular denture (direct)	Not a benefit	$95		*1 per 12 months*
D5740	Reline maxillary partial denture (direct)	Not a benefit	$95		*1 per 12 months*
D5741	Reline mandibular partial denture (direct)	Not a benefit	$95		*1 per 12 months*
D5750	Reline complete maxillary denture (indirect)	Not a benefit	$125		*1 per 12 months*
D5751	Reline complete mandibular denture (indirect)	Not a benefit	$125		*1 per 12 months*
D5760	Reline maxillary partial denture (indirect)	Not a benefit	$125		*1 per 12 months*
D5761	Reline mandibular partial denture (indirect)	Not a benefit	$125		*1 per 12 months*
D5765	Soft liner for complete or partial removable denture – indirect	Not a benefit	$125		*1 per 12 months*
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	Not a benefit	$210		*1 per 12 months*
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	Not a benefit	$210		*1 per 12 months*
D5850	Tissue conditioning, maxillary	Not a benefit	$16		*1 per 12 months*
D5851	Tissue conditioning, mandibular	Not a benefit	$16		*1 per 12 months*
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered					
D6000-D6199 VIII. IMPLANT SERVICES - Not Covered					
D6200-D6999 IX. PROSTHODONTICS, fixed					
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge)					
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 60+ months old.					
D6205	Pontic - indirect resin based composite	Not a benefit	$145		*1 per 60 months*
D6210	Pontic - cast high noble metal	Not a benefit	$425		*1 per 60 months*
D6211	Pontic - cast predominantly base metal	Not a benefit	$325		*1 per 60 months*
D6212	Pontic - cast noble metal	Not a benefit	$465		*1 per 60 months*
D6214	Pontic - titanium and titanium alloys	Not a benefit	$495		*1 per 60 months*
D6240	Pontic - porcelain fused to high noble metal	Not a benefit	$425		*1 per 60 months*
D6241	Pontic - porcelain fused to predominantly base metal	Not a benefit	$325		*1 per 60 months*
D6242	Pontic - porcelain fused to noble metal	Not a benefit	$425		*1 per 60 months*
D6243	Pontic - porcelain fused to titanium and titanium alloys	Not a benefit	$425		*1 per 60 months*
D6245	Pontic - porcelain/ceramic	Not a benefit	$495		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6250	Pontic - resin with high noble metal	Not a benefit	$425		*1 per 60 months*
D6251	Pontic - resin with predominantly base metal	Not a benefit	$325		*1 per 60 months*
D6252	Pontic - resin with noble metal	Not a benefit	$425		*1 per 60 months*
D6600	Retainer inlay - porcelain/ceramic, two surfaces	Not a benefit	$385		*1 per 60 months*
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	Not a benefit	$405		*1 per 60 months*
D6602	Retainer inlay - cast high noble metal, two surfaces	Not a benefit	$370		*1 per 60 months*
D6603	Retainer inlay - cast high noble metal, three or more surfaces	Not a benefit	$380		*1 per 60 months*
D6604	Retainer inlay - cast predominantly base metal, two surfaces	Not a benefit	$270		*1 per 60 months*
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	Not a benefit	$280		*1 per 60 months*
D6606	Retainer inlay - cast noble metal, two surfaces	Not a benefit	$370		*1 per 60 months*
D6607	Retainer inlay - cast noble metal, three or more surfaces	Not a benefit	$380		*1 per 60 months*
D6608	Retainer onlay - porcelain/ceramic, two surfaces	Not a benefit	$395		*1 per 60 months*
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	Not a benefit	$415		*1 per 60 months*
D6610	Retainer onlay - cast high noble metal, two surfaces	Not a benefit	$370		*1 per 60 months*
D6611	Retainer onlay - cast high noble metal, three or more surfaces	Not a benefit	$390		*1 per 60 months*
D6612	Retainer onlay - cast predominantly base metal, two surfaces	Not a benefit	$270		*1 per 60 months*
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	Not a benefit	$290		*1 per 60 months*
D6614	Retainer onlay - cast noble metal, two surfaces	Not a benefit	$370		*1 per 60 months*
D6615	Retainer onlay - cast noble metal, three or more surfaces	Not a benefit	$390		*1 per 60 months*
D6710	Retainer crown - indirect resin based composite	Not a benefit	$145		*1 per 60 months*
D6720	Retainer crown - resin with high noble metal	Not a benefit	$425		*1 per 60 months*
D6721	Retainer crown - resin with predominantly base metal	Not a benefit	$325		*1 per 60 months*
D6722	Retainer crown - resin with noble metal	Not a benefit	$425		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6740	Retainer crown - porcelain/ceramic	Not a benefit	$495		*1 per 60 months*
D6750	Retainer crown - porcelain fused to high noble metal	Not a benefit	$425		*1 per 60 months*
D6751	Retainer crown - porcelain fused to predominantly base metal	Not a benefit	$325		*1 per 60 months*
D6752	Retainer crown - porcelain fused to noble metal	Not a benefit	$425		*1 per 60 months*
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	Not a benefit	$425		*1 per 60 months*
D6780	Retainer crown - 3/4 cast high noble metal	Not a benefit	$425		*1 per 60 months*
D6781	Retainer crown - 3/4 cast predominantly base metal	Not a benefit	$325		*1 per 60 months*
D6782	Retainer crown - 3/4 cast noble metal	Not a benefit	$425		*1 per 60 months*
D6783	Retainer crown - 3/4 porcelain/ceramic	Not a benefit	$495		*1 per 60 months*
D6784	Retainer crown - 3/4 titanium and titanium alloys	Not a benefit	$425		*1 per 60 months*
D6790	Retainer crown - full cast high noble metal	Not a benefit	$425		*1 per 60 months*
D6791	Retainer crown - full cast predominantly base metal	Not a benefit	$325		*1 per 60 months*
D6792	Retainer crown - full cast noble metal	Not a benefit	$465		*1 per 60 months*
D6794	Retainer crown - titanium and titanium alloys	Not a benefit	$495		*1 per 60 months*
D6930	Re-cement or re-bond fixed partial denture	Not a benefit	$12		
D6940	Stress breaker	Not a benefit	$100		
D6980	Fixed partial denture repair necessitated by restorative material failure	Not a benefit	$85		
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY					
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.					
D7111	Extraction, coronal remnants - primary tooth	Not a benefit	$35		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Not a benefit	$45		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Not a benefit	$70		
D7220	Removal of impacted tooth - soft tissue	Not a benefit	$100		
D7230	Removal of impacted tooth - partially bony	Not a benefit	$190		
D7240	Removal of impacted tooth - completely bony	Not a benefit	$210		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	Not a benefit	$230		
D7250	Removal of residual tooth roots (cutting procedure)	Not a benefit	$75		
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	Not a benefit	$230		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Not a benefit	$45		
D7280	Exposure of an unerupted tooth	Not a benefit	$115		
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Not a benefit	$110		
D7283	Placement of device to facilitate eruption of impacted tooth	Not a benefit	No cost		
D7286	Incisional biopsy of oral tissue-soft	Not a benefit	$100		
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Not a benefit	$95		
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	Not a benefit	$95		
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Not a benefit	$125		
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	Not a benefit	$125		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	Not a benefit	$125		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	Not a benefit	$150		
D7471	Removal of lateral exostosis (maxilla or mandible)	Not a benefit	$150		
D7472	Removal of torus palatinus	Not a benefit	$150		
D7473	Removal of torus mandibularis	Not a benefit	$150		
D7510	Incision and drainage of abscess - intraoral soft tissue	Not a benefit	$35		
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Not a benefit	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7961	Buccal/labial frenectomy (frenulectomy)	Not a benefit	$160		
D7962	Lingual frenectomy (frenulectomy)	Not a benefit	$160		
D7970	Excision of hyperplastic tissue - per arch	Not a benefit	$115		
D7971	Excision of pericoronal gingiva	Not a benefit	$115		
D8000-D8999 XI. ORTHODONTICS – Pediatric Enrollee Benefits - Not Covered					
D8000-D8999 XI. ORTHODONTICS - Adult Enrollee Benefits					
- Including covered dependent adult children. The Enrollee must continue to be eligible during active treatment.					
- The listed Copayment for each phase of orthodontic treatment (limited or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.					
- The Retention Copayment includes adjustments and/or office visits up to 24 months.					
Pre and post orthodontic records include:					
The benefit for pre-treatment records and diagnostic services includes:		Not a benefit	$250		
D0210	Intraoral - comprehensive series of radiographic images	Not a benefit	Included		
D0322	Tomographic survey	Not a benefit	Included		
D0330	Panoramic radiographic image	Not a benefit	Included		
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	Not a benefit	Included		
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	Not a benefit	Included		
D0351	3D photographic image	Not a benefit	Included		
D0470	Diagnostic casts	Not a benefit	Included		
D0701	Panoramic radiographic image - image capture only	Not a benefit	Included		
D0702	2D cephalometric radiographic image - image capture only	Not a benefit	Included		
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	Not a benefit	Included		
D0704	3D photographic image - image capture only	Not a benefit	Included		
D0709	Intraoral - comprehensive series of radiographic images - image capture only	Not a benefit	Included		
The benefit for post-treatment records includes:		Not a benefit	$70		
D0210	Intraoral - comprehensive series of radiographic images	Not a benefit	Included		
D0470	Diagnostic casts	Not a benefit	Included		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0709	Intraoral - comprehensive series of radiographic images - image capture only	Not a benefit	Included		
D8040	Limited orthodontic treatment of the adult dentition	Not a benefit	$1,950		
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Not a benefit	$3,250		
D8090	Comprehensive orthodontic treatment of the adult dentition	Not a benefit	$3,250		
D8660	Pre-orthodontic treatment examination to monitor growth and development	Not a benefit	$25		*1 per 6 months when performed by the same Contract Dentist or dental office*
D8670	Periodic orthodontic treatment visit	Not a benefit	No cost		*Included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Not a benefit	$450		*Placement of removable retainers*
D8681	Removable orthodontic retainer adjustment	Not a benefit	No cost		
D8698	Re-cement or re-bond fixed retainer - maxillary	Not a benefit	No cost		*2 per 6 months*
D8699	Re-cement or re-bond fixed retainer - mandibular	Not a benefit	No cost		*2 per 6 months*
D8701	Repair of fixed retainer, includes reattachment - maxillary	Not a benefit	No cost		*2 per 6 months*
D8702	Repair of fixed retainer, includes reattachment - mandibular	Not a benefit	No cost		*2 per 6 months*
D8999	Unspecified orthodontic procedure, by report	Not a benefit	$250		*Includes treatment planning session*
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES					
D9110	Palliative treatment of dental pain - per visit	$45	$35		
D9211	Regional block anesthesia	Not a benefit	No cost		
D9912	Pre-visit patient screening	No cost	No cost		
D9212	Trigeminal division block anesthesia	Not a benefit	No cost		
D9215	Local anesthesia in conjunction with operative or surgical procedures	Not a benefit	No cost		
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	Not a benefit	$10		
D9222	Deep sedation/general anesthesia - first 15 minutes	Not a benefit	$55		*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	Not a benefit	$55		*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	Not a benefit	$55		*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	Not a benefit	$55		*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Not a benefit	$10		
D9311	Consultation with a medical health care professional	No cost	No cost		
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	Not a benefit	$10		
D9440	Office visit - after regularly scheduled hours	Not a benefit	$40		
D9450	Case presentation, subsequent to detailed and extensive treatment planning	Not a benefit	No cost		
D9932	Cleaning and inspection of removable complete denture, maxillary	Not a benefit	$10		
D9933	Cleaning and inspection of removable complete denture, mandibular	Not a benefit	$10		
D9934	Cleaning and inspection of removable partial denture, maxillary	Not a benefit	$10		
D9935	Cleaning and inspection of removable partial denture, mandibular	Not a benefit	$10		
D9943	Occlusal guard adjustment	Not a benefit	$24		*1 per 12 months (6 months after initial placement)*
D9944	Occlusal guard - hard appliance, full arch	Not a benefit	$175		*1 of (D9944, D9945, D9946) per 36 months*
D9945	Occlusal guard - soft appliance, full arch	Not a benefit	$45		*1 of (D9944, D9945, D9946) per 36 months*
D9946	Occlusal guard - hard appliance, partial arch	Not a benefit	$90		*1 of (D9944, D9945, D9946) per 36 months*
D9951	Occlusal adjustment - limited	Not a benefit	$40		
D9952	Occlusal adjustment - complete	Not a benefit	$90		*1 per 36 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	Not a benefit	$125		*Limited to 1 bleaching tray and gel for 2 weeks of self treatment*
D9986	Missed appointment	Not a benefit	$50		*Without 24 hour notice*
D9987	Cancelled appointment	Not a benefit	$50		*Without 24 hour notice*
D9991	Dental case management - addressing appointment compliance barriers	No cost	No cost		
D9992	Dental case management - care coordination	No cost	No cost		
D9995	Teledentistry - synchronous; real-time encounter	No cost	No cost		
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No cost	No cost		
D9997	Dental case management - patients with special health care needs	Not a benefit	No cost		

Endnotes:

Unless clarified elsewhere in the Schedule A, base metal is the Benefit. If noble or high noble metal (precious) is used for an implant/abutment supported crown, or fixed bridge retainer, indirectly fabricated post and core, inlay or onlay, the Enrollee will be charged the additional laboratory cost of the noble or high noble metal. If covered, an additional laboratory charge also applies to a titanium crown.

Porcelain/ceramic crown, pontic and fixed bridge retainer on molars is considered a material upgrade with a maximum additional charge to the Enrollee of $150 per unit.

When there are more than six crowns, retainers and/or pontics in the same treatment plan, an Enrollee may be charged an additional $125 per unit, beyond the 6th unit.

Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325 in addition to the listed Copayment. Refer to *Schedule B for Limitations and Exclusions* for additional information.

If services for a listed procedure are performed by the Contract Dentist, the Enrollee pays the specified Copayment(s). Listed procedures which require a Dentist to provide Specialist Services, and are referred by the Contract Dentist, must be authorized by this Plan. The Enrollee pays the Copayment(s) specified for such services.

Optional or upgraded procedure(s) are defined as any alternative procedure(s) presented by the Contract Dentist and formally agreed upon by financial consent that satisfies the same dental need as a covered procedure. Enrollee may elect an optional or upgraded procedure, subject to the limitations and exclusions of this Plan. The applicable charge to the Enrollee is the difference between the Contract Dentist's regularly charged fee (or contracted fee, when applicable) for the Optional or upgraded procedure and the covered procedure, plus any applicable copayment for the covered procedure.

Limitations and Exclusions of Benefits
Alpha Dental of Utah, Inc. Individual & Family
DeltaCare® USA
Basic Plan for Families

Limitations and Exclusions of Benefits for Adults (Age 19 and Older)

Limitations of Benefits for Adult

1. The frequency of certain Benefits is limited. Frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*

2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $125.00 above the listed Copayment for each of these services after the sixth unit has been provided.

3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).

4. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Contact the Customer Service department at 888-857-0337 if you have questions regarding the additional fee or name brand services.

5. Benefits provided by a pediatric Dentist are limited to children through age thirteen following an attempt by the assigned Contract Dentist to treat the child and upon prior Authorization by the plan, less applicable Copayments. The plan will consider exceptions on an individual basis if a child has a physical or mental impairment, limitation or condition which substantially interferes with that child's ability to have Benefits provided by a Contract Dentist.

6. Benefits for a soft tissue management program are limited to those parts which are listed covered services listed on *Schedule A, Description of Benefits and Copayments*. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered Benefits.

7. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's submitted fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.

   Exception to extend covered orthodontics Benefits to a cancelled or terminated Contract is as follows:

   a. For 60 days after the date coverage terminates if the Contract Orthodontist has agreed to or is receiving monthly payments; or

   b. Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Contract Orthodontist has agreed to accept or is receiving payments on a quarterly basis.

Exclusions of Benefits for Adult Enrollees

1. Any procedure that is not specifically listed as a covered Benefit under *Schedule A*, *Description of Benefits and Copayments*.

2. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.

3. Services solely for cosmetic purposes, with the exception of procedure D9975 (external bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.

4. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges).

5. Lost, stolen or broken appliances including, but not limited to, full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges), orthodontic and other appliances.

6. Procedures, appliances or restoration if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), with the exception of procedures as shown on *Schedule A, Description of Benefits and Copayments.*

7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.

8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.

9. Consultations or other diagnostic services for non-covered Benefits.

10. Dental services received from any dental facility other than the assigned Contract Dentist or an authorized dental specialist (oral surgeon, endodontist, periodontist, pediatric dentist or Contract Orthodontist) except for *Emergency Dental Services* as described in the Policy.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

12. Prescription and over-the-counter drugs.

13. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision

14. Changes in orthodontic treatment necessitated by accident of any kind.

15. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures as shown on *Schedule A, Description of Benefits and Copayments*.

16. Composite or ceramic brackets, lingual adaptation of orthodontic bands.

17. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

18. Orthodontics, including oral evaluations and all treatment, must be performed by a licensed dentist or his or her supervised staff, acting within the scope of applicable law. The dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan

19. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.

Limitations and Exclusions of Essential Health Benefits for Pediatric Enrollees (Through Age 18)

Limitations of Benefits for Pediatric Enrollees

1. Diagnostic Benefits are limited as follows:

    a) Two oral evaluations (D0120, D0150 and D0180) are covered in a 12 consecutive month period. A re-evaluation is considered included in the primary procedure and is not payable separately.

    b) Complete mouth images (posterior bitewing images and 14 periapical images plus bitewings) in conjunction with periodic examinations are limited once every thirty-six (36) consecutive months; in lieu of panoramic image.

    c) Bitewing images in conjunction with periodic examinations are limited to two (2) series of four (4) images in any twelve (12) consecutive month period.

    d) Panoramic image (D0330) is limited to once every thirty-six (36) consecutive months; in lieu of complete mouth images.

    e) Vertical bitewings (D0277) are limited up to eight images.

2. Preventive Benefits are limited as follows:

    a) Two routine prophylaxes (cleanings) (D1110, D1120) are covered in a 12 consecutive month period.

    b) A child prophylaxis (D1120) will be covered through age 13.

    c) An adult prophylaxis (D1110) will be covered for age 14 through 18.

    d) Two fluoride applications (D1206, D1208) are covered in a 12 consecutive month period.

    e) Sealants (D1351) are only covered on permanent molars without restorations or decay. One sealant per tooth is limited to once every sixty (60) consecutive month period.

    f) Sealants are not covered if there is an existing restoration (filling) that involves the biting surface of the tooth or if such a restoration is placed at the same time as the sealant.

Exclusions of Benefits for Pediatric Enrollees

The following dental services are excluded under the plan:

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.

2. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.

3. Consultations or other diagnostic services for non-covered Benefits.

4. Dental services received from any dental facility other than the assigned Contract Dentist or a preauthorized dental specialist except for *Emergency Services* as described in the Policy.

5. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

6. Prescription and over-the-counter drugs.

7. Dental conditions arising out of and due to an Enrollee's employment for which Worker's Compensation or an Employer's Liability Law is payable. The participating dental plan will provide the services at the time of need and the Enrollee will cooperate to ensure that the participating dental plan is reimbursed for such Benefits.

8. Services which were provided without cost to the Enrollee by the State government or an agency thereof, or any municipality, county or other subdivisions.

9. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Enrollee became eligible with the DeltaCare USA plan for such services.

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

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 1-866-530-9675 (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។ លោកអ្នកក៏អាចទទួលបាន ឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-866-530-9675 (TTY: 711)។ (Cambodian)

צי קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט,עמעצער דאָ קען אייַך העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אַז איר קענט באַקומען דעם דאָזיקן דאָקומענט אין אידיש שפּראַך. פֿאַר אומזיסטע הילף קענט איר אָנקלינגען אָט די דאָזיקע נומער: 1-866-530-9675 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'į' yídóołtahígíí nihee hóló. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaago ałdó' nich'į' ádoolnį́łgo bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojį' 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).



deltadentalins.com

ENROLLEE NOTICES

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

Federal Notices:

- **HIPAA Notice of Privacy Practices (NPP):** Federal regulations require insurance plans to share information about the company's privacy practices. This is called a "Notice of Privacy Practices (NPP)" and should be read when an individual first becomes an enrollee and reviewed at least every three years thereafter.

- **Gramm-Leach-Bliley (GLB):** Financial institutions and insurance companies must describe how demographic and financial information is collected and shared. California requires a state specific notice called the California Financial Privacy Notice, which is described below under the State Notices section.

- **Notice of Non-Discrimination:** We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. If you believe we have failed to provide these services or discriminated in another way on the basis of race, color,

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

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

State Notices:

- **CA Financial Privacy Notice:** This notice to Californians describes our demographic and financial information collection and sharing practices. It is similar to the Gramm-Leach-Bliley (GLB) notice described above.

- **CA Grievance Process:** This notice describes our procedure for processing and resolving enrollee grievances and gives the address and phone number to make a complaint. Californians are encouraged to read this notice when they first enroll and annually thereafter.
- **CA Timely Access to Care:** California law requires health plans to provide timely access to care. This law sets limits on how long enrollees must wait to get appointments and telephone assistance.

- **CA Tissue and Organ Donations:** This notice informs subscribers of the societal benefits of organ donation and the methods they can use to become organ and/or tissue donors. California regulations require every health plan to provide this information upon enrollment and annually thereafter.

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

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

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330

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