Summary of Dental Benefits and Coverage Disclosure Matrix(SDBC)

Part I: GENERAL INFORMATION

Plan Name: Delta Dental Individual & Family™ Delta Dental PPO™ Family Dental PPO **Name of Product:** Delta Dental
Type of Product Line: DPPO **Plan Phone #:** 888-282-8978
Effective Date: 01/01/25 **Plan Website:** deltadentalins.com/hcx

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE deltadentalins.com/hcx OR CALL 888-282-8978.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	$50 per individual **(Age 19 and Older);** $75 per individual / $150 per family **(Child up to age 19)**	$50 per individual **(Age 19 and Older);** $75 per individual / $150 per family **(Child up to age 19)**
Orthodontia	$75 per individual / $150 per family **(Child up to age 19)**	$75 per individual / $150 per family **(Child up to age 19)**

- **The deductible applies to all services except the following services: Preventive & Diagnostic.**
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your plan to provide dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	$1,500 per individual **(Age 19 and older);** None **(Child up to age 19)**	$1,500 per individual **(Age 19 and older);** No **(Child up to age 19)**
Lifetime or Annual Maximum for Orthodontia	None **(Child up to age 19)**	No **(Child up to age 19)**

- **Annual maximum** is the maximum dollar amount your plan will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. **Not all services accrue to the annual maximum.**
- **Lifetime maximum** means the maximum dollar amount your plan providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **Your dental benefit package has a 6 consecutive month waiting period for Major Services for age 19 and older. This waiting period is waived with proof of prior coverage.**

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Preventive & Diagnostic	0%	0%	• Child up to Age 19: 1 per patient per provider • Age 19 and Older: 1 per lifetime per provider • Refer to the Disclosure Form for the full limitation and exclusion
Bitewing X-ray	Preventive & Diagnostic	0%	0%	• Child up to Age 19: 1 per 36 months • Age 19 and Older: 1 per 60 months • Refer to the Disclosure Form for the full limitation and exclusion
Cleaning	Preventive & Diagnostic	0%	0%	• Child up to Age 19: 1 per 6 months • Age 19 and Older: 2 per calendar year • Refer to the Disclosure Form for the full limitation
Filling	Basic	20%	30%	• Child up to Age 19: 1 per 12 months for primary teeth, 1 per 36 months for permanent teeth • Refer to the Disclosure Form for the full limitation and exclusion
Extraction, Erupted Tooth or Exposed Root	Major	50%	50%	• Child up to Age 19: 1 per lifetime • Age 19 and Older: 1 per lifetime; 6-month waiting period applies Refer to the Disclosure Form for the full limitation and exclusion
Root Canal	Major	50%	50%	• Child up to Age 19: 1 per lifetime • Age 19 and Older: 1 per lifetime; 6-month waiting period applies • Refer to the Disclosure Form for the full limitation and exclusion
Scaling and Root Planing	Major	50%	50%	• Child up to Age 19: 1 per quadrant per 24 months; age 13+; • Age 19 and Older: 1 per quadrant per 24 months; 6-month waiting period applies • Refer to the Disclosure Form for the full limitation and exclusion
Ceramic Crown	Major	50%	50%	• Child up to Age 19: 1 per 60 months; age 13+; • Age 19 and Older: 1 per 60 months; 6-month

				waiting period applies • Refer to the Disclosure Form for the full limitation and exclusion
Removable Partial Denture	Major	50%	50%	• Child up to Age 19: 1 per 60 months • Age 19 and Older: 1 per 60 months; 6-month waiting period applies • Refer to the Disclosure Form for the full limitation and exclusion
Extraction, Erupted Tooth with Bone Removal	Major	50%	50%	• Child up to Age 19: 1 per lifetime; • Age 19 and Older: 1 per lifetime; 6-month waiting period applies • Refer to the Disclosure Form for the full limitation and exclusion
Orthodontia	Orthodontia	Up to Age 19: 50% Age 19 and Older: Not Covered	Up to Age 19: 50% Age 19 and Older: Not Covered	• Coverage is restricted to: Medically Necessary for Enrollees up to age 19. Refer to the Disclosure Form for the full limitation and exclusion

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	**Sam Needs a Tooth Filled**	**Maria Needs a Crown**
New patient exam, x-rays (full-mouth x-ray) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Total Cost of Care	In-network: $**400** Out-of-network: $**550**	Total Cost of Care	In-network: $**150** Out-of-network: $**200**	Total Cost of Care	In-network: $**1,300** Out-of-network: $**1,750**
Deductible	In-network: Child up to Age 19: Not Applicable Age 19 and Older: Not Applicable Out-of-network: Child up to Age 19: Not Applicable Age 19 and Older: Not Applicable	Deductible	In-network: Child up to Age 19: $75 Age 19 and Older: $50 Out-of-network: Child up to Age 19: $75 Age 19 and Older: $50	Deductible	In-network: Child up to Age 19: $75 Age 19 and Older: $50 Out-of-network: Child up to Age 19: $75 Age 19 and Older: $50

Annual Maximum (Plan Will Pay)	In-network: Child up to Age 19: None Age 19 and Older: $1,500 Out-of-network: up to Age 19: No Age 19 and Older: $1,500	Annual Maximum (Plan Will Pay)	In-network: Child up to Age 19: None Age 19 and Older: $1,500 Out-of-network: up to Age 19: No Age 19 and Older: $1,500	Annual Maximum (Plan Will Pay)	In-network: Child up to Age 19: None Age 19 and Older: $1,500 Out-of-network: up to Age 19: No Age 19 and Older: $1,500

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Patient Cost (copayment or coinsurance)	In-network: Child up to Age 19: $0 Age 19 and Older: $0 Out-of-network: Child up to Age 19: 10% Age 19 and Older: 10%	Patient Cost (copayment or coinsurance)	In-network: Child up to Age 19: 20% Age 19 and Older: 20% Out-of-network: Child up to Age 19: 30% Age 19 and Older: 30%	Patient Cost (copayment or coinsurance)	In-network: Child up to Age 19: 50% Age 19 and Older: 50% Out-of-network: Child up to Age 19: 50% Age 19 and Older: 50%
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** Child up to Age 19: $0 Age 19 and Older: $0 **Out-of-network:** Child up to Age 19: $55 Age 19 and Older: $55	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** Child up to Age 19: $90 Age 19 and Older: $70 **Out-of-network:** Child up to Age 19: $112.50 Age 19 and Older: $95	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** Child up to Age 19: $350 Age 19 and Older: $675 **Out-of-network:** Child up to Age 19: $912.50 Age 19 and Older: $900
Summary of what is not covered or subject to a limitation:	**Full Mouth X-ray:** • Child up to Age 19: 1 per 36 months per provider • Age 19 and Older: 1 per 60 months **Oral Exam:** • Child up to Age 19: 1 per patient	Summary of what is not covered or subject to a limitation:	• Child up to Age 19: 1 per 12 months for primary teeth, 1 per 36 months for permanent teeth	Summary of what is not covered or subject to a limitation:	• Child up to Age 19 Maximum Out of Pocket is $350 per calendar year • Child up to Age 19: 1 per 60 months • Age 19 and Older: 1 per 60 months • Age 19 and

	per provider • Age 19 and Older: 1 per lifetime per provider **Cleaning:** • Child up to Age 19: 1 per 6 months • Age 19 and Older: 2 per calendar year				Older: Major services have a 6 consecutive month waiting period. This waiting period is waived with proof of prior coverage.

DELTA DENTAL®

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

COVERED CALIFORNIA

Delta Dental Individual & Family™

Delta Dental PPO™
Family Dental PPO

Combined Policy and Disclosure Form **("Policy")**

Provided by:

Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105
888-282-8978 (TTY: 711)
deltadentalins.com

CoveredCA.com
800-300-1506 (TTY: 888-889-4500)

POLICY

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

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

READ THIS POLICY AND ATTACHMENTS CAREFULLY

Our enrollment materials advise Enrollees that this Policy is available upon request, prior to enrollment, by contacting Our Customer Care. A matrix describing this Plan's major Benefits and coverages is included as *Attachment C, Information Concerning Benefits for Delta Dental Individual & Family Dental PPO* ("Attachment C"). Enrollees may also obtain information about Benefits by calling Our Customer Care at **888-282-8978 (TTY: 711).**

10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

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

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

Michael G. Hankinson, Esq.
Executive Vice President, Chief Legal and Compliance Officer

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INTRODUCTION

We are pleased to welcome You to the Delta Dental Individual & Family PPO Plan ("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 visit the Dentist but to visit one on a regular basis.

Eligibility under this Plan is determined by the Exchange. This Plan provides dental Benefits for adults and children as defined in the following sections:

- ***Eligibility Requirements for Pediatric Benefits*** **("Essential Health Benefits")**
- ***Eligibility Requirements for Adult Benefits***

Using This Policy

This Policy, including Attachments, 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 this Plan works and how to obtain dental care. Please read this Policy completely and carefully. Keep in mind that "You" and "Your" mean the individuals who are covered under this Policy. "We," "Us" and "Our" always refer to Delta Dental. In addition, please read the "Definitions" section as it will explain any words with special or technical meanings. Persons with Special Health Care Needs should read the "Special Health Care Needs" provision in this Policy.

Request Confidential Communications

You may request to receive communications about Your protected health information from Us at an alternate location or by an alternate method. If You would like to submit a new request for confidential communications or revise or cancel an existing one, email it to **departmentriskethicsandcompliance@delta.org**, mail it to the address below or visit Our website. Your request will be valid until You cancel it or submit a new one.

Contact Us

If You have any questions about Your coverage that are not answered in this Policy, visit Our website at **deltadentalins.com** or call Our Customer Care. A representative can help with: answering questions about Your plan, explaining Benefits, locating a Delta Dental Provider, language assistance services, filing or checking the status of a claim or filing a grievance. You may also access Our automated information line at **888-282-8978** to obtain information about Your eligibility, Benefits or claim status. If You prefer to write to Us, please mail it to:

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

Identification Number

You should provide Your identification ("ID") number to Your Delta Dental Provider whenever You receive dental services. Your ID number should be included on all claims submitted for payment. ID cards are not required but may be obtained by visiting Our website at **deltadentalins.com**.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

DEFINITIONS

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

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

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

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

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

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

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

Delta Dental PPO Contracted Fee ("PPO Provider's Contracted Fee"): the fee for each Single Procedure that a PPO Provider has contractually agreed to accept as payment in full for covered services under this Plan.

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

Delta Dental Premier® Contracted Fee ("Premier Provider's Contracted Fee"): the fee for each Single Procedure that a Premier Provider has contractually agreed to accept as payment in full for covered services under this Plan.

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

Delta Dental Service Area: all geographic areas in the state of California in which We are licensed as a specialized health care service plan to offer this Plan.

Department of Managed Health Care: a department of the California Health and Human Services Agency who has charge of regulating specialized health care service plans. Also referred to as the "Department" or "DMHC."

Effective Date: the original date this Plan starts.

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

Emergency Dental Condition: dental symptoms and/or pain that are so severe that a reasonable person would believe that, without immediate attention by a Provider, it could reasonably be expected to result in any of the following:

- placing the patient's health in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part
- death

Emergency Dental Service: a dental screening, examination and evaluation by a Provider or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Provider to determine if an Emergency Dental Condition exists and, if it does, the care, treatment and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Dental Condition, within the capability of the facility.

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

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

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

Exchange: the California Health Benefit Exchange also referred to as "Covered California™."

Grace Period: the period of at least 30 consecutive days beginning the day the Notice of Start of Grace Period is dated.

Maximum: the maximum dollar amount We will pay toward the cost of dental care covered under this Plan.

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

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

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

Notice of End of Coverage: the notice sent by Us notifying You that Your coverage has been cancelled.

Notice of Start of Grace Period: the notice sent by Us notifying You that Your coverage will be cancelled unless the Premium amount due is received no later than the last day of the Grace Period.

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

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

Policy: this agreement between Us and the Primary Enrollee including any application supplied by the Exchange and any attachments. This Policy constitutes the entire agreement between the parties.

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

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 an Enrollee has an Effective Date mid-year due to a Qualifying Status Change or other exceptional circumstance as determined by the Exchange.

Policyholder: the Primary Enrollee who enrolls for coverage. If this Policy is offered as a child-only or multi-children only Policy by the Exchange, 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, stepparent, adoptive parent or a Spouse of the Eligible Pediatric Individual.

Premium: the amount payable as provided in the *Policy Information* Attachment included with this Policy.

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

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

Provider: a person licensed to practice dentistry when and where services are performed. A Provider also includes a dental partnership, dental professional corporation or dental clinic. Also referred to as a Dentist.

Qualified Individual: an individual determined by the Exchange to be eligible to enroll through the Exchange.

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-child or death of a child);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee moves);
- court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by the Exchange.

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

Special Enrollment Period: a time the Exchange has established outside the yearly Open Enrollment Period when You can sign-up for coverage.

Special Health Care Need: a physical or mental impairment, limitation or condition that substantially interferes with an Enrollee's ability to obtain Benefits. Examples of such a Special Health Care Need are: 1) the Enrollee's inability to obtain access to the Provider's facility because of a physical disability; and 2) the Enrollee's inability to comply with the Provider's instructions during examination or treatment because of physical disability or mental incapacity.

Spouse: a person related to or a domestic partner of the Primary Enrollee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where this Policy is issued and delivered; or
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides.

Submitted Fee: the amount that the Provider bills and enters on a Claim Form for a specific Procedure Code.

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 an Enrollee must be enrolled under this Policy for specific services to be covered.

We, Us and Our: Delta Dental

You and Your: the individuals who are covered under this Plan.

ELIGIBILITY AND ENROLLMENT

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

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

Eligibility Requirements for Pediatric Benefits

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

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

Pediatric Enrollees eligible for Pediatric Benefits are:

- a Primary Enrollee or an emancipated minor to age 19; and/or
- a Primary Enrollee's Spouse under age 19 and dependent children from birth to age 19. Dependent children include natural children, step-children, adopted children, children placed for adoption and children of a Spouse.

Eligibility Requirements for Adult Benefits

Primary Enrollees and Dependent Enrollees are Qualified Individuals as determined by the Exchange who are eligible and have enrolled for Adult Benefits under this Policy. A Qualified Individual must satisfy the Exchange'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 and older; and/or
- a Primary Enrollee's Spouse age 19 and older and Eligible Dependents from age 19 to age 26. Eligible Dependents include: natural children, step-children, adopted children, children placed for adoption and children of a Spouse.

An enrolled dependent child who reaches age 26 during the benefit year may remain enrolled as a Dependent Enrollee until the end of the benefit year. The dependent coverage will end on the last day of the benefit year during which the Dependent Enrollee becomes ineligible.

Dependent children 26 years of age and older may continue eligibility for Adult Benefits if:

1) they are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and

2) they are chiefly dependent on the Primary Enrollee or Spouse for support and maintenance.

3) We will notify the Primary Enrollee at least 90 days prior to the date the dependent child attains the limiting age that their coverage will terminate unless We receive proof of the criteria described above within 60 days of the Primary Enrollee's receipt of Our notification. Such requests will not be made more than once a year following a two (2) year period after this dependent child reaches the limiting age. Eligibility will continue as long as the dependent child relies on the Primary Enrollee or Spouse for support and maintenance because of a physically or mentally disabling injury, illness or condition.

PREMIUM PAYMENT RESPONSIBILITIES

Your Premium is determined by the plan design chosen at the time of enrollment. Premiums are listed in the *Policy Information* Attachment included with this Policy. The Primary Enrollee is responsible for making timely Premium payments.

Prepayment Fees

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

Delta Dental of California
P.O. Box 660138
Dallas, TX 75266-0138

Rate Guarantee

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

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 calling Customer Care at **888-282-8978**.

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 Exchange prior to any applicable Open Enrollment Period. The Primary Enrollee may change plan selections with the Exchange during the Open Enrollment Period. Provided We continue to make this Policy available through the Exchange at the renewal period:

- The Primary Enrollee may elect to choose this Policy, subject to the applicable Premium through the Exchange for this Plan at the time of renewal; or
- The Primary Enrollee may not have to make an election through the Exchange in subsequent Open Enrollment Periods to continue coverage. Refer to the Exchange rules regarding automatic renewal of coverage.

CANCELLATION, RESCISSION OR NON-RENEWAL OF COVERAGE

You have the right to terminate coverage under this Policy by contacting Covered CA. The effective date of a requested termination will be at least 14 days from the date of Our receipt of the request for termination. If coverage is terminated because the Enrollee is covered by Medicaid, the last day of coverage with Us is the day before the new coverage is effective.

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

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

- You are no longer eligible through the Exchange or under the terms of this Policy;
- Premiums not paid on or before the last day of the Grace Period. Please refer to the "Cancellation of Enrollment Due to Non-Payment of Premium" provision;

- Our demonstrating that You committed fraud or intentional misrepresentation of material fact in obtaining Benefits under the terms of this Plan;
- You change to a new policy through the Exchange; or
- Our 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 Exchange, termination is effective the last day of the month following the month that the Exchange notifies You of lack of eligibility. If You are no longer eligible due to age, termination is effective on the date reported by the Exchange and You should contact the Exchange to find out if Special Enrollment Periods apply.

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

In the event of cancellation of enrollment by Us, (except in the case of fraud or deception in obtaining Benefits from Us or knowingly permitted such fraud or deception by another), We will, within 30 days, return to You the pro rata portion of the Premiums paid to Us which corresponds to any unexpired period for which payment had been received, together with any amounts due on claims, if any, less any amounts owed to Us.

CANCELLATION OF ENROLLMENT

Cancellation of Enrollment Due to Non-Payment of Premium

Grace Period

If Your Premium payment is not received by the first day of the month, Your account will be considered late. We will send You a Notice of Start of Grace Period advising that a payment delinquency has triggered a Grace Period. A Grace Period is the time period beginning the day the Notice of Start of Grace Period is dated.

The Notice of Start of Grace Period advises You that Your coverage will be terminated unless the full Premium amount due is paid on or before the last day of the Grace Period. It will also include important information needed to maintain uninterrupted coverage such as: an explanation of the Grace Period, the beginning and end dates of the Grace Period, the dollar amount past due, the date of the last day of paid coverage and a statement explaining the consequences of losing coverage.

Coverage will continue during the Grace Period; however, You are financially responsible for any and all Premiums, copayments, Enrollee Coinsurance and Deductible amounts, including those incurred for services received during the Grace Period. If, after receiving the Notice of Start of Grace Period, Your account remains delinquent after the Grace Period expires, Your coverage will be terminated. We will then send You a Notice of End of Coverage within five (5) calendar days after the date coverage ends stating the effective date, reason for cancellation of coverage and whom to contact for assistance.

Cancellation of Enrollment Other Than Non-Payment of Premium

For cancellation, rescission or non-renewal other than for non-payment of Premium, We will send You a Notice of Cancellation, Rescission or Nonrenewal. A Notice of End of Coverage will be provided to You for all cancellations after the date coverage has ended, but no later than five (5) calendar days after the date coverage has ended. This notice will include the reason for cancellation and whom to contact for assistance.

If coverage is terminated for any cause, We are not required to preauthorize services beyond the termination date or to pay for services provided after the termination date, except for services begun while Your Policy was in effect or if You have a cancellation grievance pending for reasons other than non-payment of Premium submitted prior to the effective date of Your cancellation, rescission or non-renewal of coverage. Please refer to the provisions below regarding Your right to submit a grievance.

Right to Submit Grievance Regarding Cancellation, Rescission or Non-Renewal of Your Plan Enrollment, Subscription or Contract

If You believe Your enrollment has been, or will be, improperly cancelled, rescinded or not renewed You have at least 180 days from the date of the notice You allege to be improper to submit a grievance to Us and/or to the Department of Managed Health Care ("DMHC"). We will provide You and the DMHC with a disposition or pending status on Your grievance within three (3) calendar days of Our receipt of Your grievance.

For grievances submitted prior to the effective date of the cancellation, rescission or non-renewal for reasons other than non-payment of Premium, We will continue to provide coverage while the grievance is pending with Us or the DMHC. During the period of continued coverage, You are responsible for paying Premiums and any and all copayments, Enrollee Coinsurance, or Deductible amounts as required under Your coverage.

OPTION 1 – YOU MAY SUBMIT A GRIEVANCE TO YOUR PLAN.

You may submit online at **deltadentalins.com**, or call **888-282-8978** or write to:

Delta Dental of California
Attn: Correspondence Department
P.O. Box 1860
Alpharetta, GA 30023-1860

You may want to submit Your grievance to Us first if You believe Your cancellation, rescission, or non-renewal is the result of a mistake. Grievances should be submitted as soon as possible.

We will resolve Your grievance or provide a pending status within three (3) calendar days. If You do not receive a response from Us within three (3) calendar days, or if You are not satisfied in any way with Our response, You may submit a grievance to the DMHC as detailed under Option 2 below.

OPTION 2 – YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DMHC.

You may submit a grievance to the DMHC without first submitting it to Us or after You have received Our decision on Your grievance. Grievances may be submitted to the DMHC online at **www.Healthhelp.ca.gov** or by mailing Your written grievance to:

Help Center
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725

You may contact the DMHC for more information on filing a grievance at:

Phone: 1-888-466-2219
TDD: 1-877-688-9891
Fax: 1-916-255-5241

Reinstatement

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

Our acceptance of the proper Premiums after termination of this Policy and without requiring a new application will reinstate this Policy as though it had never terminated, unless We, within 20 business days of receipt of such payment, either:

- refuse Your payment, or
- issue You a new Policy accompanied by written notice clearly stating those aspects in which the new policy differs from this terminated Policy in Benefits, coverage or otherwise.

If You submit a grievance for cancellation, rescission or non-renewal of coverage, including cancellation due to non-payment of Premium, and it is determined that the cancellation is improper, Your coverage may be reinstated retroactive to the date of cancellation, rescission or non-renewal. You are responsible for paying any and all outstanding Premium amounts accrued from the effective date of the cancellation, rescission or non-renewal of coverage before reinstatement. Any outstanding Premium must be paid prior to reinstatement.

OVERVIEW OF DENTAL BENEFITS

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

Benefits, Limitations and Exclusions

This Plan provides Pediatric Benefits and Adult Benefits using the Delta Dental PPO™ Network within the Delta Dental Service Area in the state of California during the Policy Year. We will pay Benefits for the types of dental services as described in the Attachments attached to this Policy.

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

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

Teledentistry Services

Teledentistry services are when a Dentist delivers dental services through telehealth or telecommunications to diagnose dental issues, offer dental care advice or determine appropriate dental treatment. It can be a convenient alternative option to an in-person dental appointment.

There are two types of Teledentistry services:

- **Synchronous** is real-time interaction such as a video call with Your PPO Dentist.
- **Asynchronous** is when a video or photo of Your dental issue is sent to Your PPO Dentist and a reply is sent later.

A Teledentistry appointment is covered as an oral evaluation under the Diagnostic and Preventive procedure category as shown in *Attachment A*. It is also covered on the same basis and to the same extent that the Benefit is covered through in-person diagnosis, consultation or treatment and is inclusive in the overall patient management care and not a separately payable service. Although the fees for Teledentistry are included in the fees that may apply to other dental services received, there are no frequency limitations imposed for Teledentistry access.

Please note that not all PPO Dentists offer Teledentistry services and that not all dental conditions can be treated through Teledentistry visits. We recommend contacting Your Dentist and Delta Dental Customer Service for additional information.

If You are experiencing a life-threatening emergency, immediately call **911**.

Enrollee Coinsurance

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

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

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

Pre-Treatment Estimates

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

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

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

Non-Covered Services

IMPORTANT: If You opt to receive dental services that are not covered services under this Plan, a participating Provider may charge You their usual and customary rate for those services. Prior to providing You with dental services that are not a covered Benefit, Your Provider should provide You with a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about Your dental coverage options, You may call Our Customer Care at **888-282-8978**. To fully understand Your coverage, carefully review this Policy.

Coordination of Benefits

This Plan is the "primary" plan except when Pediatric Benefits are provided under a Qualified Health Plan. If this Plan is the "primary" plan, We will not reduce Benefits but if this Plan is the "secondary" plan We determine Benefits after those of the primary plan and will pay the lesser of the amount that We would pay in the absence of any other dental benefit coverage or Your total out-of-pocket cost under the primary plan for Benefits covered under this Plan.

SELECTING YOUR PROVIDER

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

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

We recommend keeping a record of payment for Pediatric Benefits. However, You may request from Us anytime an up-to-date accrual balance toward Your annual Deductible and/or OOPM. If You would like to request this accrual information, please call Us at **888-282-8978**. We will mail it to the address on file unless You elect to receive it electronically.

Free Choice of Provider

You may visit any Provider for Your covered treatment whether the Provider is a PPO Provider, Premier Provider or a Non-Delta Dental Provider. **This Plan, offered through the Exchange, is a PPO plan and the greatest Benefits – including out-of-pocket savings – occur when You choose a PPO Provider.** We will also pay for services received from dental schools or clinics by students of dentistry, a clinician or instructors who are contracted with Us. To take full advantage of Your Benefits, We highly recommend You verify a Provider's participation status within a Delta Dental network with Your dental office before each appointment. Review this section for an explanation of Our payment procedures to understand the method of payments applicable to Your Provider selection and how that may impact Your out-of-pocket costs.

Locating a PPO Provider

You may access information through Our website at **deltadentalins.com** and then by selecting the Delta Dental PPO Network. You may also call Our Customer Care and one of Our representatives will assist You. We can provide You with information regarding a Provider's network participation, specialty and office location.

Choosing a PPO Provider

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

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

Choosing a Premier Provider

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

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

Choosing a Non-Delta Dental Provider

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

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

Additional Obligations of PPO and Premier Providers

- The PPO Provider and Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Us after satisfaction of the Deductible and Enrollee Coinsurance. You do not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Provider and Premier Provider will complete the dental Claim Form and submit it to Us for reimbursement.
- The PPO Provider will accept the PPO Provider's Contracted Fees as payment in full for covered services and will not balance bill if there is a difference between the Submitted Fees and the PPO Provider's Contracted Fees.
- By statute, Our agreement with Our PPO Providers and Premier Providers ensures that You will not be responsible to those Providers for any money We owe.

Upon termination of a PPO Provider's agreement with Us, We will be liable for Benefits for the completion of treatment for Single Procedures begun prior to the termination of the agreement. The terminating PPO Provider will complete:

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

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

If You will be materially or adversely affected by the termination, breach of contract or the inability of a PPO Provider to perform, We will send You written notice within a reasonable amount of time.

Emergency Dental Services

Delta Dental PPO Providers are available 24 hours a day, 7 days a week to provide treatment in the case of an Emergency Dental Condition. However, if You are unable to reach a Delta Dental PPO Provider, You may seek treatment from any dental Provider of Your choice. Payment for Emergency Dental Services will be made subject to the provisions described in this Policy.

Timely Access to Care

Delta Dental PPO and Premier Providers have agreed waiting times to Enrollees for appointments for care which will never be greater than the following timeframes:

- for emergency care, 24 hours a day, 7 days a week;
- for any urgent care, 72 hours for appointments consistent with the Enrollee's individual needs;
- for any non-urgent care, 36 business days; and
- for any preventive services, 40 business days.

During non-business hours, You have access to a PPO or Premier Provider's answering machine, answering service, cell phone or pager for guidance on what to do and whom to contact for urgent dental services or if You are experiencing an Emergency Dental Condition including while outside the Delta Dental Service Area.

If You call Our Customer Care, a representative will answer Your call within 10 minutes during normal business hours.

Language Assistance Services

We offer qualified interpretation services to limited-English proficient Enrollees at no cost to the Enrollee at all points of contact in any modern language including when an Enrollee is accompanied at the dental office by a family member or friend who can provide language interpretation services.

If You need language interpretation services, materials translated into Your preferred language or in an alternate format, please call **888-282-8978 (TTY: 711)**. You may also visit Our Provider Directory on Our website which includes self-reported languages by Our Delta Dental Providers.

How to Submit a Claim

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

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

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

Payment Guidelines

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

If You or Your Provider file a claim for services more than 12 months after the date You received the services, payment may be denied. If the services were received from a Non-Delta Dental Provider, You are still responsible for the full cost. If We fail to pay a Non-Delta Dental Provider, You may be liable to that Provider for the entire cost of services. We will reimburse You for any portion of the Provider's fee that is covered by this Plan.

If the payment is denied because Your PPO or Premier Provider failed to submit the claim on time, You may not be responsible for that payment. However, if You did not tell Your PPO or Premier Provider that You were covered under this Policy at the time You received the service, You may be responsible for the cost of that service.

If You need more information concerning how Providers are reimbursed under this Plan, please Our Customer Care at **888-282-8978**.

Provider Relationships

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

Second Opinion

We obtain second opinions through Regional Consultant members of Our Quality Review Committee who conduct clinical examinations, prepare objective reports of dental conditions, and evaluate treatment that is proposed or has been provided.

We will authorize such an examination prior to treatment when necessary to make a Benefits determination in response to a request for a Pre-Treatment Estimate. We will also authorize a second opinion after treatment if You have a complaint regarding the quality of the care provided. We will notify You and Your treating Dentist when a second opinion is necessary and appropriate and direct You to the Regional Consultant selected by Us to perform the clinical examination. When We authorize a second opinion through a Regional Consultant, We will pay for all charges.

You may otherwise obtain a second opinion about treatment from any Dentist You choose and claims for the examination may be submitted to Us for payment. We will pay such claims in accordance with the Benefits of this Plan.

Special Health Care Needs

If You believe You have a Special Health Care Need, You should call Customer Care at **888-282-8978 (TTY: 711)**. We will confirm that a Special Health Care Need exists and what arrangements can be made to assist You in obtaining Benefits. We will not be responsible for the failure of any Provider to comply with any law or regulation concerning structural office requirements that apply to a Delta Dental Provider treating Enrollees with Special Health Care Needs.

Facility Accessibility

Many dental facilities provide Us with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding dental facility accessibility, call Customer Care at **888-282-8978** or visit Our website at **deltadentalins.com**.

GRIEVANCES AND APPEALS

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

If You have a grievance regarding eligibility, the denial of dental services or claims, Our policies, procedures or operations or the quality of care for dental services performed by a Delta Dental Provider, You may call Us at **888-282-8978 (TTY: 711)**, complete and submit a **Delta Dental PPO Enrollee Grievance Form** online or mail Your grievance to:

Delta Dental of California
P.O. Box 1860
Alpharetta, GA 30023-1860

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

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

"Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or Provider, including quality of care concerns and includes a complaint, dispute, request for reconsideration or appeal made by You or Your representative. Where this Plan is unable to distinguish between a grievance and an inquiry, it will be considered a grievance.

"Complaint" is the same as "grievance."

"Complainant" is the same as "grievant" and means the person who filed the grievance including You, Your representative or other individual with authority to act on Your behalf.

Within five (5) calendar days of the receipt of any complaint, a quality management coordinator will forward to You a written acknowledgment of Your complaint which will include the date of receipt and plan contact information. 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 calendar days of receipt of a complaint.

Our grievance system ensures all plan Enrollees have access to and can fully participate in Our grievance process by providing assistance for those with limited-English proficiency or with visual or other communicative impairments. Such assistance includes, but is not limited to, translations of grievance procedures, forms and plan responses to grievances as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. If You are in need of these services and/or have questions about Our grievance process, please call Customer Care at **888-282-8978 (TTY: 711)** and/or visit Our website at **deltadentalins.com** to complete and submit a **Delta Dental PPO Enrollee Grievance Form**.

Our grievance system allows Enrollees to file grievances for at least 180 calendar days following any incident or action that is the subject of an Enrollee's dissatisfaction. We do not discriminate against any Enrollee on the grounds that the complainant filed a grievance.

You may file a complaint with the DMHC after completing Our grievance process or if You have been involved in Our grievance process for more than 30 days. You may seek assistance or file a grievance immediately with the DMHC in cases involving an imminent and serious threat to Your health including, but not limited to, severe pain, potential loss of life, limb or major bodily function. In such case, We will provide You with a written statement on the disposition or pending status of Your grievance no later than three (3) calendar days from the date of Our receipt of Your grievance. You may file a complaint with the DMHC immediately if You are experiencing an Emergency Dental Condition.

Complaints Involving an Adverse Benefit Determination

If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of this Policy, We will consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of the consulting Dentist will be available upon request. If You believe that the decision was denied on the grounds that it was not medically necessary, You may contact the DMHC to determine if the decision is eligible for an independent medical review. You will not be discriminated against in any way by Us for filing a grievance.

California law requires that We provide You with the following information:

The CA Department of Managed Health Care is responsible for regulating health care service plans. If You have a grievance against Your health plan, You should first telephone Your health plan at **888-282-8978** and use Your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to You. If You need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Your health plan, or a grievance that has remained unresolved for more than 30 days, You may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If You are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

GENERAL PROVISIONS

Public Policy Participation by Enrollees

Our Board of Directors includes Enrollees who participate in establishing Our public policy regarding Enrollees through periodic review of Our Quality Assessment program reports and communications from Enrollees. Enrollees may submit any suggestions regarding Our public policy in writing to:

Delta Dental of California
Customer Care
P.O. Box 997330
Sacramento, CA 95899-7330

Entire Policy; Changes

This Policy, including any application and attachments, constitutes the entire contract. 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, attachments 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

We will not rescind or limit any provisions of this Policy once You are covered under this Plan unless it can be demonstrated that You performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of this Policy. If We intend to rescind coverage by demonstrating the aforementioned, We will send a notice to the Primary Enrollee at least 31 days prior to the effective date of the rescission explaining the reason(s) for rescinding coverage and informing the Enrollee of their right to appeal this rescission with the director of the DMHC.

After 24 months following the issuance of this Policy, We will not rescind this Policy for any reason. We will not cancel or limit any provisions of this Policy or raise Premiums due to any omissions, misrepresentations or inaccuracies in the application form, whether willful or not.

Clinical Examination

Before approving a claim, We will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider or from hospitals in which a Provider's care is provided, such information and records relating to the treatment provided to You as may be required to administer the claim. Examination may be required by a dental consultant retained by Us in or near Your community or residence. We will, in every case, hold such information and records confidential.

Notice of Claim Form

We will give You or Your Provider, on request, 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 in the "Written Notice of Claim/Proof of Loss" provision.

If the Claim Form is not furnished by Us within 15 days after requested by You or Your Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to Us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. You or Your Provider may download a Claim Form from Our website.

Written Notice of Claim/Proof of Loss

We must be given written proof of loss within 12 months after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated). 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. Send Your Notice of Claim/Proof of Loss to Us at:

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

Time of Payment

Claims payable under this Policy for any loss other than loss for which this Policy provides a 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. We will notify You and Your Provider of any additional information needed to process the claim within this 30 day period.

To Whom Benefits Are Paid

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

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 California where this Policy was entered into and is to be performed. Any part of this Policy that conflicts with the laws of California, specifically Chapter 2.2 of Division 2 of the California Health and Safety Code and Chapter 1 of Division 1, of Title 28 of the California Code of Regulations, or federal law is hereby amended to conform to the minimum requirements of such laws. Any provision required to be in this Policy by either of the above will bind Us whether or not provided in this Policy.

Holding Company

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

Third Party Administrator ("TPA")

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

Organ and Tissue Donation

Donating organ and tissue provides many societal benefits. Organ and tissue donation allow recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If You are interested in organ donation, please speak to Your physician. Organ donation begins at the hospital when a person is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

Impossibility of Performance

Neither party (Policyholder or Delta Dental) 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 do not discriminate on the basis of race, color, national origin, age, disability, or sex including sex stereotypes and gender identity. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We:

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

If You need these services, call Our Customer Care at **888-282-8978 (TTY: 711)**.

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 Care representative or by mail.

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
Phone Numbers: **888-282-8978 (TTY: 711)**
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, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019; 1-800-537-7697 (TDD)

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

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

Summary of Benefits and Coverage	Family Dental Plan			
	Coinsurance Plan			
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Pediatric Dental Essential Health Benefits		Adult Dental	
	Up to Age 19		Age 19 and Older	
Actuarial Value	86.2%	86.2%	Not Calculated	Not Calculated
	In-Network: Delta Dental PPO[1]	Out-of-Network: Non-Delta Dental PPO[1]	In-Network: Delta Dental PPO[1]	Out-of-Network: Non-Delta Dental PPO[1]
Individual Deductible each Calendar Year[2,3]	$75	$75	$50	$50
Family Deductible each Calendar Year (Two or more children)[3]	$150	$150	Not Applicable	Not Applicable
Individual Out of Pocket Maximum each Calendar Year[4]	$350	None	Not Applicable	Not Applicable
Family Out of Pocket Maximum each Calendar Year (Two or More Children)[4]	$700	None	Not Applicable	Not Applicable
Office Copay	$0	$0	$0	$0
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d)	None	None	Major Services limited to enrollees who have been enrolled in the Policy for 6 consecutive months, waived with proof of prior coverage[5]	Major Services limited to enrollees who have been enrolled in the Policy for 6 consecutive months, waived with proof of prior coverage[5]
Annual Maximum (the maximum amount the dental plan will pay in the Calendar Year)	None	None	$1,500	

Procedure Category	Service Type	Member Cost Share[6]	Member Cost Share[6]	Member Cost Share[6]	Member Cost Share[6]
Diagnostic & Preventive	Oral Exam[8]	No charge	10%	No charge	10%
	Preventive - Cleaning	No charge	10%	No charge	10%
	Preventive - X-ray	No charge	10%	No charge	10%
	Sealants per Tooth	No charge	10%	Not Covered	Not Covered
	Topical Fluoride Application	No charge	10%	Not Covered	Not Covered
	Space Maintainers - Fixed	No charge	10%	Not Covered	Not Covered
Basic Services	Restorative Procedures Periodontal Maintenance Services	20% Deductible Applies	30% Deductible Applies	20% Deductible Applies	30% Deductible Applies
Major Services	Periodontics (other than maintenance) Endodontics Crowns and Casts Prosthodontics Oral Surgery	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies
Orthodontia	Medically Necessary Orthodontia[7]	50% Deductible Applies	50% Deductible Applies	Not Covered	Not Covered

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

[2] Each adult is responsible for an individual Deductible. Adult Deductible is waived for Diagnostic and Preventive Services.

[3] In a coinsurance plan, each child is responsible for the individual Deductible unless the family Deductible has been met. Once a child's individual Deductible or the family Deductible is reached, cost sharing applies until the child's Out-of-Pocket Maximum is reached.

In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network Deductible, if applicable, as well as the family Out-of-Pocket Maximum.

In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network Deductible, if applicable, and do not accumulate to the family Out-of-Pocket Maximum.

Pediatric Deductible is waived for Diagnostic and Preventive Services.

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

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

[5] The six month waiting period (Adult only) for major services must be waived upon a member's provision of proof of prior comparable dental coverage. This waiting period will be prorated on a one-to-one monthly basis upon a member's provision of proof of prior comparable dental coverage of less than six months. Covered California leaves it to the plan to determine acceptable documentation to verify prior proof of coverage. Covered California leaves it to the plan to determine the maximum allowable gap in coverage before proration of the six month waiting period would no longer occur. Dental services obtained via a discount health plan are not considered "comparable" dental coverage for purposes of counting towards the waiting period.

[6] Delta Dental will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for covered services. Note: Policy Benefit Levels differ between Delta Dental PPO Providers and Non-Delta Dental PPO Providers. The greatest benefits – including out-of-pocket savings – occur when covered services are received by a Delta Dental PPO Provider. The amount charged to Enrollees for covered services performed by a Non-Delta Dental PPO Provider may be above that accepted by Delta Dental PPO Providers, and Enrollees will be responsible for balance billed amounts.

[7] Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.

[8] To the extent the dental plans can offer Teledentistry, it would be offered at no charge.

[9] These Endnotes do not limit an issuer's obligations to comply with applicable Federal, State, or local laws, rules, or regulations. In the event an issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirements of these Endnotes, an issuer will comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these Endnotes exceed requirements imposed by law, an issuer will comply with the requirements in these Endnotes.

Attachment B
Services, Limitations and Exclusions

Description of Dental Services for Adult Benefits (age 19 and older)

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

- **Diagnostic and Preventive Services**

(1)	Diagnostic:	procedures to aid the Provider in determining required dental treatment, including images and oral exams.
(2)	Preventive:	cleaning, including scaling in presence of generalized moderate or severe gingival inflammation – full mouth (periodontal maintenance is considered to be a Basic Service for payment purposes).
(3)	Specialist Consultations:	opinion or advice requested by a general dentist.

- **Basic Services**

(1)	General Anesthesia or IV Sedation:	when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
(2)	Periodontal Cleanings:	periodontal maintenance.
(3)	Palliative:	emergency treatment to relieve pain.
(4)	Restorative:	amalgam and resin-based composite restorations (fillings) and prefabricated restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

- **Major Services**

(1)	Crowns and Inlays/Onlays:	treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
(2)	Prosthodontics:	procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges.
(3)	Oral Surgery:	extractions and certain other surgical procedures (including pre- and post-operative care).
(4)	Endodontics:	treatment of diseases and injuries of the tooth pulp.
(5)	Periodontics:	treatment of gums and bones supporting teeth.
(6)	Denture Repairs:	repair to partial or complete dentures, including rebase procedures and relining.

- **Note on additional Benefits during pregnancy**

  When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Policy include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Limitations for Adult Benefits (age 19 and older)

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

Examples of Optional Services:
a) a composite restoration instead of an amalgam restoration on posterior teeth;
b) a crown where a filling would restore the tooth;
c) an inlay/onlay instead of an amalgam restoration; or
d) porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown).

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

(2) Delta Dental will pay for oral examinations (except after hours exams and exams for observation) no more than twice in a calendar year.

(3) Delta Dental will pay for cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (including periodontal maintenance or any combination thereof) no more than twice in a Calendar Year. A full mouth debridement is allowed once in a lifetime when the Enrollee has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three years and counts toward the cleaning frequency in the year provided. Note that periodontal maintenance, Procedure Codes that include periodontal maintenance, and full mouth debridement are covered as a Basic Benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.

(4) Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.

(5) A caries risk assessment is allowed once in 12 months. An interim caries arresting medicament application is covered once per tooth every six (6) months when Enrollee has a caries risk assessment and documentation with a finding of high risk.

(6) Image limitations:

a) We will limit the total reimbursable amount to the Provider's Accepted Fee for a comprehensive series of radiographic images when the fees for any combination of intraoral images in a single treatment series meet or exceed the Accepted Fee for a comprehensive intraoral series.
b) Benefits are limited to either one (1) comprehensive intraoral series or one (1) panoramic image once every 60 months.
c) If a panoramic image is taken in conjunction with a comprehensive intraoral series, We will limit reimbursement to the Provider's Accepted Fee for the comprehensive intraoral series, and the fee for the panoramic image will be the responsibility of the enrollee.
d) Panoramic images are not considered part of a comprehensive intraoral series.
e) Bitewing images are limited to one (1) time per Calendar Year for age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
f) Bitewing images of any type are included in the fee of a comprehensive series when taken within 6 months of the comprehensive images.
g) Image capture procedures are not separately billable services.

(7) Pulp vitality tests are allowed once per day when definitive treatment is not performed.

(8) Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency. Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a 12-month period and included if reported, with any other examination on the same date of service and Provider office.

(9) Delta Dental will not cover to replace amalgam and resin-based composite restorations (fillings) and prefabricated restorations within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations, including reattachment of a tooth fragment, within 24 months are included in the fee for the original restoration.

(10) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

(11) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.

(12) Pulpal debridement and partial pulpotomy for apexogenesis are limited to once per lifetime.

(13) Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(14) Hemisection (including any root removal), not including root canal therapy, root amputation per root, internal root repair of perforation defects and incomplete endodontic therapy; inoperable, unrestorable or fractured tooth are limited to once in a lifetime.

(15) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(16) Pin retention is covered not more than once in any 24-month period.

(17) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required images or select Diagnostic procedures.

(18) Periodontal limitations:

a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service.
b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same dentist/dental office.
c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
d) Guided tissue regeneration is not benefited in conjunction with soft tissue grafts in the same surgical area.
e) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
f) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.

(19) Oral Surgery services are covered once in a lifetime except removal of benign odontogenic cysts or tumors, excision of benign lesions and incision and drainage procedures, which are covered once in the same day.

(20) General anesthesia, intravenous moderate (conscious) sedation is a benefit only when provided by a dentist in conjunction with covered oral surgery procedures or selected endodontic and periodontal surgical procedures.

(21) Crowns and Inlays/Onlays are covered not more often than once in any 60 month period except when Delta Dental determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(22) Core buildup, including any pins, is covered not more than once in any 60 month period.

(23) Post and core services are covered not more than once in any 60 month period.

(24) Crown repairs are covered not more than once in any 60 month period. Crowns, inlays/onlays and fixed bridges include repairs for twenty-four (24) months following installation.

(25) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(26) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.

(27) Prosthodontic appliances that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance is not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory.

(28) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(29) Recementation of Crowns, Inlays/Onlays, indirectly fabricated or prefabricated post and core, or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.

(30) Occlusal adjustment - limited, is allowed once in a 60-month period.

(31) Delta Dental limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.

a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period.
c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline or rebase service.
d) Recementation of fixed partial dentures is limited to once in a lifetime.

(32) Frenulectomy is only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician, or if there is a papilla penetrating frenum interfering with closure of a diastema.

(33) The fees for synchronous/asynchronous Teledentistry services are considered inclusive in overall patient management and are not separately payable service.

Exclusions for Adult Benefits (age 19 and older)

Delta Dental does not pay Benefits for:

(1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(2) cosmetic surgery or procedures for purely cosmetic reasons, including teeth whitening and veneers.

(3) maxillofacial prosthetics.

(4) provisional and/or temporary restorations.

(5) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.

(6) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(7) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(8) charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected endodontic and periodontal surgical procedures.

(9) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(10) services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.

(11) indirectly fabricated resin-based Inlays/Onlays.

(12) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(13) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(14) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, image duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(15) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(16) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(17) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.

(18) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

(19) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(20) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric images, oral/facial photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.

(21) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(22) services or supplies for sealants, fluoride, space maintainers, apexification and transseptal fiberotomy/supra crestal fiberotomy.

(23) missed and/or cancelled appointments.

(24) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

(25) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

(26) dental case management motivational interviewing and patient education to improve oral health literacy.

(27) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

(28) extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.

(29) diabetes testing.

(30) corticotomy (specialized oral surgery procedures associated with orthodontics).

(31) antigen or antibody testing.

(32) counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

(33) supplies or services for sleep apnea

Description of Dental Services for Pediatric Benefits (under age 19)

Delta Dental will pay or otherwise discharge the Policy Benefit Level shown in Attachment A for Essential Health Benefits and benefits listed below in the Schedule of Covered Services when provided by a Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthodontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health. Benefits for medically necessary orthodontics will be provided in periodic payments based on continued enrollment.

- **Diagnostic and Preventive Services**
  - (1) Diagnostic: procedures to aid the Provider in determining required dental treatment, including images and oral exams.
  - (2) Preventive: cleaning, including scaling in presence of generalized moderate or severe gingival inflammation – full mouth (periodontal maintenance is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
  - (3) Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
  - (4) Specialist Consultations: opinion or advice requested by a general dentist.

- **Basic Services**
  - (1) General Anesthesia or IV Sedation: when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
  - (2) Periodontal Cleanings: periodontal maintenance.
  - (3) Palliative: emergency treatment to relieve pain.
  - (4) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- **Major Services**
  - (1) Crowns: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
  - (2) Prosthodontics: procedures for construction of partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
  - (3) Oral Surgery: extractions and certain other surgical procedures (including pre-and post-operative care).
  - (4) Endodontics: treatment of diseases and injuries of the tooth pulp.
  - (5) Periodontics: treatment of gums and bones supporting teeth.
  - (6) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.
- **Note on Early Periodic Screening, Diagnosis and Treatment (EPSDT) Benefit.**

  Administration of this plan design must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
- **Note on additional Benefits during pregnancy**

  When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Policy include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Schedule of Covered Services

The Procedure Codes and nomenclature in this schedule are copyright of the American Dental Association. This table represents Procedure Codes and nomenclature excerpted from the version of Current Dental Terminology (CDT®) in effect at the date of this printing. Delta Dental's administration of Benefits, limitations and exclusions under this Plan at all times will be based on the current version of CDT whether or not a revised table is provided.

Procedure Code	Procedure Description and Limitations
Diagnostic and Preventive Services	
D0120	Periodic oral evaluation - established patient: once every 6 months per provider
D0140	Limited oral evaluation - problem focused: once per patient per provider
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150	Comprehensive oral evaluation - new or established patient: once per patient per provider
D0160	Detailed and extensive oral evaluation - problem focused, by report: once per patient per provider
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit): 6 in 3 months, not to exceed 12 in 12 months
D0171	Re-evaluation - post-operative office visit
D0180	Comprehensive periodontal evaluation - new or established patient
D0210	Intraoral - comprehensive series of radiographic images: once per provider every 36 months
D0220	Intraoral - periapical first radiographic image: maximum of 20 images (D0220, D0230) in 12 months per provider
D0230	Intraoral - periapical each additional radiographic image: maximum of 20 images (D0220, D0230) in 12 months per provider
D0240	Intraoral - occlusal radiographic image: maximum of 2 in 6 months per provider
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector: once per date of service
D0251	Extra-oral posterior dental radiographic image: 4 per date of service
D0270	Bitewing - single radiographic image: once per date of service
D0272	Bitewings - two radiographic images: once every 6 months per provider
D0273	Bitewings - three radiographic image
D0274	Bitewings - four radiographic images: once every 6 months per provider, age 10 and older
D0277	Vertical bitewings - 7 to 8 radiographic images: maximum of 4
D0310	Sialography
D0320	Temporomandibular joint arthrogram, including injection: maximum of 3 per date of service
D0322	Tomographic survey: twice in 12 months per provider
D0330	Panoramic radiographic image: once in 36 months per provider
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis: twice in 12 months per provider
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally: maximum of 4 per date of service
D0396	3D printing of a 3D dental surface scan
D0460	Pulp vitality tests
D0470	Diagnostic casts: once per provider
D0502	Other oral pathology procedures, by report
D0601	Caries risk assessment and documentation, with a finding of low risk: one procedure (D0601, D0602, D0603) every 12 months per provider
D0602	Caries risk assessment and documentation, with a finding of moderate risk: one procedure (D0601, D0602, D0603) every 12 months per provider
D0603	Caries risk assessment and documentation, with a finding of high risk: one procedure (D0601, D0602, D0603) every 12 months per provider

D0701	Panoramic radiographic image – image capture only
D0702	2-D cephalometric radiographic image – image capture only
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only
D0705	Extra-oral posterior dental radiographic image – image capture only
D0706	Intraoral – occlusal radiographic image – image capture only
D0707	Intraoral – periapical radiographic image – image capture only
D0708	Intraoral – bitewing radiographic image – image capture only
D0709	Intraoral – comprehensive series of radiographic images – image capture only
D0801	3D dental surface scan - direct: once per date of service
D0802	3D dental surface scan - indirect: once per date of service
D0803	3D facial surface scan - direct: once per date of service
D0804	3D facial surface scan - indirect: once per date of service
D0999	Unspecified diagnostic procedure, by report
D1110	Prophylaxis - adult: once every 6 months
D1120	Prophylaxis - child: once every 6 months
D1206	Topical application of fluoride varnish: once every 6 months and frequency limitation applies towards D1208
D1208	Topical application of fluoride – excluding varnish: once every 6 months and frequency limitation applies towards D1206
D1310	Nutritional counseling for control of dental disease
D1320	Tobacco counseling for the control and prevention of oral disease
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use
D1330	Oral hygiene instructions
D1351	Sealant - per tooth: once per permanent molar every 36 months per provider if they are without caries (decay) or restorations on the occlusal surface.
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth: once per tooth every 36 months per provider
D1353	Sealant repair - per tooth
D1354	Interim caries arresting medicament application - per tooth: once every 6 months
D1355	Caries preventive medicament application – per tooth
D1510	Space maintainer - fixed - unilateral- per quadrant: once per quadrant per patient through age 17
D1516	Space maintainer - fixed – bilateral, maxillary: once per arch per patient through age 17
D1517	Space maintainer - fixed – bilateral, mandibular: once per arch per patient through age 17
D1520	Space maintainer - removable - unilateral- per quadrant: once per quadrant per patient through age 17
D1526	Space maintainer - removable – bilateral, maxillary: once per arch per patient through age 17
D1527	Space maintainer - removable – bilateral, mandibular: once per arch per patient through age 17
D1551	Re-cement or re-bond bilateral space maintainer – maxillary: once per provider per quadrant or arch through age 17
D1552	Re-cement or re-bond bilateral space maintainer - mandibular: once per provider per quadrant or arch through age 17

D1553	Re-cement or re-bond unilateral space maintainer - per quadrant: once per provider per quadrant or arch through age 17
D1556	Removal of fixed unilateral space maintainer - per quadrant
D1557	Removal of fixed bilateral space maintainer - maxillary
D1558	Removal of fixed bilateral space maintainer - mandibular
D1575	Distal shoe space maintainer – fixed, unilateral- per quadrant: once per quadrant per lifetime; under age 9
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation: once every 6 months
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician
D9311	Consultation with a medical health care professional
D9995	Teledentistry - synchronous; real-time encounter
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review
D9997	Dental case management - patients with special health care needs
Basic Services	
D2140	Amalgam - one surface, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2150	Amalgam - two surfaces, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2160	Amalgam - three surfaces, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2161	Amalgam - four or more surfaces, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2330	Resin-based composite - one surface, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2331	Resin-based composite - two surfaces, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2332	Resin-based composite - three surfaces, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2335	Resin-based composite - four or more surfaces (anterior): once in 12 months for primary teeth, once in 36 months for permanent teeth
D2390	Resin-based composite crown, anterior: once in 12 months for primary teeth , once in 36 months for permanent teeth
D2391	Resin-based composite - one surface, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2392	Resin-based composite - two surfaces, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2393	Resin-based composite - three surfaces, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2394	Resin-based composite - four or more surfaces, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration: once in 12 months per provider
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core: performed in conjunction with recementation of existing or new crown and is not separately payable
D2920	Re-cement or re-bond crown: once in 12 months per provider
D2921	Reattachment of tooth fragment, incisal edge or cusp: once in 12 months.
D2928	Prefabricated porcelain/ceramic crown – permanent tooth: once in 36 months
D2929	Prefabricated porcelain/ceramic crown – primary tooth: once in 12 months

D2930	Prefabricated stainless steel crown - primary tooth: once in 12 months
D2931	Prefabricated stainless steel crown - permanent tooth; once in 36 months
D2932	Prefabricated resin crown: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2933	Prefabricated stainless steel crown with resin window: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2940	Protective restoration: once per tooth in 6 months per provider
D2941	Interim therapeutic restoration - primary dentition: once per tooth in 6 months per provider
D2949	Restorative foundation for an indirect restoration
D2950	Core buildup, including any pins when required
D2951	Pin retention - per tooth, in addition to restoration: once per tooth for permanent teeth
D2952	Post and core in addition to crown, indirectly fabricated: once per tooth
D2953	Each additional indirectly fabricated post - same tooth
D2954	Prefabricated post and core in addition to crown: once per tooth
D2955	Post removal
D2957	Each additional prefabricated post - same tooth
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework
D2976	Band stabilization – per tooth
D2980	Crown repair necessitated by restorative material failure
D2989	Excavation of a tooth resulting in the determination of non-restorability
D2991	Application of hydroxyapatite regeneration medicament – per tooth
D2999	Unspecified restorative procedure, by report
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit
D4910	Periodontal maintenance: once in a calendar quarter and only in the 24 months following the last scaling and root planing, age 13+
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure: once per tooth in 24 months
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site
D9110	Palliative treatment of dental pain per visit: once per date of service per provider regardless of the number of teeth and/or areas treated
D9120	Fixed partial denture sectioning
D9210	Local anesthesia not in conjunction with operative or surgical procedures: once per date of service per provider
D9211	Regional block anesthesia
D9212	Trigeminal division block anesthesia
D9215	Local anesthesia in conjunction with operative or surgical procedures
D9219	Evaluation for moderate sedation, deep sedation, or general anesthesia
D9222	Deep sedation/general anesthesia – first 15 minutes
D9223	Deep sedation/general anesthesia – each subsequent 15-minute increment
D9230	Inhalation of nitrous oxide/anxiolysis, analgesia
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15-minute increment
D9248	Non-intravenous conscious sedation: once per date of service
D9410	House/extended care facility call: once per patient per date of service

D9420	Hospital or ambulatory surgical center call
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed: once per date of service per provider
D9440	Office visit - after regularly scheduled hours: once per date of service per provider
D9610	Therapeutic parenteral drug, single administration: maximum of 4 injections per date of service
D9612	Therapeutic parenteral drugs, two or more administrations, different medications
D9910	Application of desensitizing medicament: once in 12 months per provider for permanent teeth
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report: once per date of service per provider
D9951	Occlusal adjustment - limited: once in 12 months, age 13+
D9999	Unspecified adjunctive procedure, by report
Major Services	
D2710	Crown - resin-based composite (indirect): once in 5 years, age 13+
D2712	Crown - 3/4 resin-based composite (indirect): once in 5 years, age 13+
D2721	Crown - resin with predominantly base metal: once in 5 years, age 13+
D2740	Crown - porcelain/ceramic: once in 5 years, age 13+
D2751	Crown - porcelain fused to predominantly base metal: once in 5 years, age 13+
D2781	Crown - 3/4 cast predominantly base metal: once in 5 years, age 13+
D2783	Crown - 3/4 porcelain/ceramic: once in 5 years, age 13+
D2791	Crown - full cast predominantly base metal: once in 5 years, age 13+
D3110	Pulp cap - direct (excluding final restoration)
D3120	Pulp cap - indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament: once per primary tooth
D3221	Pulpal debridement, primary and permanent teeth: once per tooth
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development: once per permanent tooth
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration): once per primary tooth
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration): once per primary tooth
D3310	Endodontic therapy, anterior tooth (excluding final restoration): once per tooth for initial root canal treatment (root canal therapy retreatment processed as D3346)
D3320	Endodontic therapy, premolar tooth (excluding final restoration): once per tooth for initial root canal treatment (root canal therapy retreatment processed as D3347)
D3330	Endodontic therapy, molar tooth (excluding final restoration): once per tooth for initial root canal treatment (root canal therapy retreatment processed as D3348)
D3331	Treatment of root canal obstruction; non-surgical access
D3333	Internal root repair of perforation defects
D3346	Retreatment of previous root canal therapy - anterior
D3347	Retreatment of previous root canal therapy - premolar
D3348	Retreatment of previous root canal therapy - molar
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.): once per permanent tooth

D3352	Apexification/recalcification - interim medication replacement: once per permanent tooth
D3410	Apicoectomy - anterior
D3421	Apicoectomy - premolar (first root)
D3425	Apicoectomy - molar (first root)
D3426	Apicoectomy (each additional root)
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site
D3430	Retrograde filling - per root
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery
D3471	Surgical repair of root resorption - anterior
D3472	Surgical repair of root resorption – premolar
D3473	Surgical repair of root resorption – molar
D3910	Surgical procedure for isolation of tooth with rubber dam
D3999	Unspecified endodontic procedure, by report
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
D4249	Clinical crown lengthening - hard tissue
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site
D4341	Periodontal scaling and root planing - four or more teeth per quadrant: once per quadrant in 24 months; age 13+
D4342	Periodontal scaling and root planing - one to three teeth per quadrant: once per quadrant in 24 months; age 13+
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff): included in fee for completed service (D4210, D4211, D4260, D4261) if same provider. Once per patient to different provider.
D4999	Unspecified periodontal procedure, by report: age 13+
D5110	Complete denture - maxillary: once in 5 years
D5120	Complete denture - mandibular: once in 5 years
D5130	Immediate denture - maxillary: once per patient
D5140	Immediate denture - mandibular: once per patient
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth): once in 5 years
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth): once in 5 years
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years

D5221	immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth): once in 5 years
D5222	immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth): once in 5 years
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
D5410	Adjust complete denture - maxillary: per provider, once per date of service and twice in 12 months
D5411	Adjust complete denture - mandibular: per provider, once per date of service and twice in 12 months
D5421	Adjust partial denture - maxillary: per provider, once per date of service and twice in 12 months
D5422	Adjust partial denture - mandibular: per provider, once per date of service and twice in 12 months
D5511	Repair broken complete denture base, mandibular: per provider, once per arch per date of service and twice in 12 months
D5512	Repair broken complete denture base, maxillary: per provider, once per arch per date of service and twice in 12 months
D5520	Replace missing or broken teeth - complete denture (each tooth): per provider, 4 per arch per date of service and twice per arch in 12 months
D5611	Repair resin denture base, mandibular: per provider, once per arch per date of service and twice per arch in 12 months
D5612	Repair resin denture base, maxillary: per provider, once per arch per date of service and twice per arch in 12 months
D5621	Repair cast partial framework, mandibular: per provider, once per arch per date of service and twice per arch in 12 months
D5622	Repair cast partial framework, maxillary: per provider, once per arch per date of service and twice per arch in 12 months
D5630	Repair or replace broken retentive/clasping materials - per tooth: per provider, 3 per date of service and twice per arch in 12 months
D5640	Replace broken teeth - per tooth: per provider, 4 per arch per date of service and twice per arch in 12 months
D5650	Add tooth to existing partial denture: per provider, 3 per date of service and once per tooth
D5660	Add clasp to existing partial denture - per tooth: per provider, 3 per date of service and twice per arch in 12 months
D5730	Reline complete maxillary denture (direct): once in 12 months
D5731	Reline complete mandibular denture (direct): once in 12 months
D5740	Reline maxillary partial denture (direct): once in 12 months
D5741	Reline mandibular partial denture (direct): once in 12 months
D5750	Reline complete maxillary denture (indirect): once in 12 months
D5751	Reline complete mandibular denture (indirect): once in 12 months
D5760	Reline maxillary partial denture (indirect): once in 12 months
D5761	Reline mandibular partial denture (indirect): once in 12 months
D5850	Tissue conditioning, maxillary: twice per prosthesis in 36 months
D5851	Tissue conditioning, mandibular: twice per prosthesis in 36 months
D5862	Precision attachment, by report: included in fee for prosthetic and restorative procedure and not separately payable
D5863	Overdenture – complete maxillary: once in 5 years
D5864	Overdenture – partial maxillary: once in 5 years

D5865	Overdenture – complete mandibular: once in 5 years
D5866	Overdenture - partial mandibular: once in 5 years
D5899	Unspecified removable prosthodontic procedure, by report
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification: twice in 12 months
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5951	Feeding aid
D5952	Speech aid prosthesis, pediatric
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification: twice in 12 months
D5960	Speech aid prosthesis, modification: twice in 12 months
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint
D5991	Vesiculobullous disease medicament carrier
D5999	Unspecified maxillofacial prosthesis, by report
D6010	Surgical placement of implant body: endosteal implant
D6011	Surgical access to an implant body (second stage implant surgery)

D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant
D6013	Surgical placement of mini implant
D6040	Surgical placement: eposteal implant
D6050	Surgical placement: transosteal implant
D6055	Connecting bar – implant supported or abutment supported
D6056	Prefabricated abutment – includes modification and placement
D6057	Custom fabricated abutment – includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	Abutment supported porcelain fused to metal crown (noble metal)
D6062	Abutment supported cast metal crown (high noble metal)
D6063	Abutment supported cast metal crown (predominantly base metal)
D6064	Abutment supported cast metal crown (noble metal)
D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported crown- porcelain fused to high noble alloys
D6067	Implant supported crown- high noble alloys
D6068	Abutment supported retainer for porcelain/ceramic FPD
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074	Abutment supported retainer for cast metal FPD (noble metal)
D6075	Implant supported retainer for ceramic FPD
D6076	Implant supported retainer FPD- porcelain fused to high noble alloys
D6077	Implant supported retainer for metal FPD- high noble alloys
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments
D6082	Implant supported crown - porcelain fused to predominantly base alloys
D6083	Implant supported crown - porcelain fused to noble alloys
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys
D6085	Interim implant crown: included in fee for implant services and not separately payable
D6086	Implant supported crown - predominantly base alloys
D6087	Implant supported crown - noble alloys
D6088	Implant supported crown - titanium and titanium alloys
D6089	Accessing and retorquing loose implant screw - per screw
D6090	Repair implant supported prosthesis, by report
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment
D6092	Re-cement or re-bond implant/abutment supported crown: once in 12 months per provider

D6093	Re-cement or re-bond implant/abutment supported fixed partial denture: once in 12 months per provider
D6094	Abutment supported crown - titanium and titanium alloys
D6095	Repair implant abutment, by report
D6096	Remove broken implant retaining screw
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys
D6098	Implant supported retainer - porcelain fused to predominantly base alloys
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys
D6100	Surgical removal of implant body
D6105	Removal of implant body not requiring bone removal or flap elevation
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys
D6121	Implant supported retainer for metal FPD – predominantly base alloys
D6122	Implant supported retainer for metal FPD – noble alloys
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys
D6190	Radiographic/surgical implant index, by report
D6191	Semi-precision abutment – placement
D6192	Semi-precision attachment – placement
D6194	Abutment supported retainer crown for FPD- titanium and titanium alloys
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant: 1 in 24 months
D6198	Remove interim implant component
D6199	Unspecified implant procedure, by report
D6211	Pontic - cast predominantly base metal: once in 5 years, age 13+
D6241	Pontic - porcelain fused to predominantly base metal: once in 5 years, age 13+
D6245	Pontic - porcelain/ceramic: once in 5 years, age 13+
D6251	Pontic - resin with predominantly base metal: once in 5 years, age 13+
D6721	Retainer crown - resin with predominantly base metal: once in 5 years, age 13+
D6740	Retainer crown - porcelain/ceramic: once in 5 years, age 13+
D6751	Retainer crown - porcelain fused to predominantly base metal: once in 5 years, age 13+
D6781	Retainer crown - 3/4 cast predominantly base metal: once in 5 years, age 13+

D6783	Retainer crown - 3/4 porcelain/ceramic: once in 5 years, age 13+
D6784	Retainer crown ¾ - titanium and titanium alloys: once in 5 years, age 13+
D6791	Retainer crown - full cast predominantly base metal: once in 5 years, age 13+
D6930	Re-cement or re-bond fixed partial denture: once in 12 months per same provider
D6980	Fixed partial denture repair necessitated by restorative material failure: once in 12 months of initial placement or previous repair by same provider
D6999	Unspecified fixed prosthodontic procedure, by report: once in 12 months of initial placement by same provider
D7111	Extraction, coronal remnants - primary tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth: once per arch regardless of the number of teeth involved for permanent anterior teeth
D7280	Exposure of an unerupted tooth
D7283	Placement of device to facilitate eruption of impacted tooth
D7284	Excisional biopsy of minor salivary glands
D7285	Incisional biopsy of oral tissue -hard (bone, tooth): once per arch per date of service
D7286	Incisional biopsy of oral tissue -soft: maximum of 3 per date of service
D7290	Surgical repositioning of teeth: once per arch for permanent teeth for patients in active orthodontic treatment
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report: once per arch
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7340	Vestibuloplasty - ridge extension (secondary epithelialization): once per arch in 5 years
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue): once per arch
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated

D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7465	Destruction of lesion(s) by physical or chemical method, by report
D7471	Removal of lateral exostosis (maxilla or mandible): once per quadrant
D7472	Removal of torus palatinus: once in the patient's lifetime
D7473	Removal of torus mandibularis: once per quadrant
D7485	Reduction of osseous tuberosity: once per quadrant
D7490	Radical resection of maxilla or mandible
D7509	Marsupialization of odontogenic cyst
D7510	Incision and drainage of abscess - intraoral soft tissue: once per quadrant per same date of service
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces): once per quadrant per same date of service
D7520	Incision and drainage of abscess - extraoral soft tissue
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue: once per date of service
D7540	Removal of reaction producing foreign bodies, musculoskeletal system: once per date of service
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone: once per quadrant per date of service
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)
D7630	Mandible - open reduction (teeth immobilized, if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus closed reduction may include stabilization of teeth
D7671	Alveolus, open reduction may include stabilization of teeth
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla open reduction
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction
D7740	Mandible - closed reduction
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction
D7770	Alveolus - open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth

D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7871	Non-arthroscopic lysis and lavage
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy: lavage and lysis of adhesions
D7874	Arthroscopy: disc repositioning and stabilization
D7875	Arthroscopy: synovectomy
D7876	Arthroscopy: discectomy
D7877	Arthroscopy: debridement
D7880	Occlusal orthotic device, by report
D7881	Occlusal orthotic device adjustment: once per date of service per provider, two in 12 months per provider
D7899	Unspecified TMD therapy, by report
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7920	Skin graft (identify defect covered, location and type of graft)
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy - segmented or subapical
D7945	Osteotomy - body of mandible
D7946	Lefort I (maxilla - total)
D7947	Lefort I (maxilla - segmented)
D7948	Lefort II or lefort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft
D7949	Lefort II or lefort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach
D7952	Sinus augmentation via a vertical approach
D7955	Repair of maxillofacial soft and/or hard tissue defect
D7961	Buccal/labial frenectomy (frenulectomy)
D7962	Lingual frenectomy (frenulectomy)

D7963	Frenuloplasty: once per arch per date of service
D7970	Excision of hyperplastic tissue - per arch: once per arch per date of service
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity: once per quadrant per date of service
D7979	Non-surgical sialolithotomy
D7980	Surgical sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft - mandible or facial bones, by report
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar: once per arch per date of service
D7999	Unspecified oral surgery procedure, by report
D9950	Occlusion analysis - mounted case: once in 12 months, age 13+
D9952	Occlusal adjustment - complete: once in 12 months, age 13+
Orthodontia	
D8080	Comprehensive orthodontic treatment of the adolescent dentition: once per patient per phase of treatment
D8210	Removable appliance therapy: once per patient, ages 6 through 12
D8220	Fixed appliance therapy: once per patient, ages 6 through 12
D8660	Pre-orthodontic treatment examination to monitor growth and development: once every 3 months for a maximum of 6 during patient's lifetime
D8670	Periodic orthodontic treatment visit: once per calendar quarter
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s): once per arch for each authorized phase of orthodontic treatment
D8681	Removable orthodontic retainer adjustment. Included in fee for complete orthodontic service and not separately payable.
D8696	Repair of orthodontic appliance – maxillary: once per appliance
D8697	Repair of orthodontic appliance – mandibular: once per appliance
D8698	Re-cement or re-bond fixed retainer – maxillary: once per provider
D8699	Re-cement or re-bond fixed retainer – mandibular: once per provider
D8701	Repair of fixed retainer, includes reattachment – maxillary: Included in fee for complete orthodontic service and not separately payable.
D8702	Repair of fixed retainer, includes reattachment – mandibular: Included in fee for complete orthodontic service and not separately payable.
D8703	Replacement of lost or broken retainer – maxillary: once per arch
D8704	Replacement of lost or broken retainer – mandibular: once per arch
D8999	Unspecified orthodontic procedure, by report

Limitations for Pediatric Benefits (under age 19)

(1) Claims shall be processed in accordance with Delta Dental's standard processing policies. The processing policies may be revised from time to time; therefore, Delta Dental shall use the processing policies that are in effect at the time the claim is processed. Delta Dental may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

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

(3) Exam (covered codes only between D0120 – D0180) and cleaning limitations (D1110, D1120):

a) Delta Dental will pay for periodic oral examinations (D0120) (except after hours exams (D9440) and exams for observation (D9430)) no more than once every six (6) months per provider and routine cleanings (D1110, D1120), including scaling in presence of generalized moderate or severe gingival inflammation (D4346) (including periodontal maintenance (D4910) or any combination thereof) no more than once every six (6) months. Detailed (D0160), limited (D0140) and comprehensive (D0150, D0180) oral examinations are covered once per patient per provider. Re-evaluation – limited, problem focused exams (established patient; not post-operative visits) (D0170) are covered up to six (6) times in a three (3) month period and up to a maximum of 12 in a 12 month period. This procedure is not a benefit when provided on the same date of service with a detailed and extensive oral evaluation. See note on additional Benefits during pregnancy.
b) Periodontal maintenance (D4910) is limited to Enrollees age 13 and older once in a calendar quarter and only in the 24 months following the last scaling and root planing. A full mouth debridement (D4355) is included in in the fee for other periodontal procedures and is not payable separately.
c) Note that periodontal maintenance (D4910), Procedure Codes that include periodontal maintenance and full mouth debridement (D4355) are covered as a Basic Benefit, and routine cleanings (D1110, D1120) including scaling in presence of generalized moderate or severe gingival inflammation (D4346) are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance (D4910) is only covered when performed following active periodontal therapy (D4260, D4261, D4341, D4342).
d) Caries risk assessments (D0601, D0601,D0603) are allowed once in 12 months.
e) Interim caries arresting medicament applications (D1354) are covered once per tooth every six (6) months when Enrollee has a caries risk assessment and documentation with a finding of high risk.

(4) Image limitations:

a) We will limit the total reimbursable amount to the Provider's Accepted Fee for a comprehensive+ series of radiographic images when the fees for any combination of intraoral images in a single treatment series meet or exceed the Accepted Fee for a comprehensive intraoral series.
b) A complete intraoral series and panoramic image are each limited to once every 36 months per provider.
c) If a panoramic image is taken in conjunction with a comprehensive intraoral series, We will limit reimbursement to the Provider's Accepted Fee for the comprehensive intraoral series, and the fee for the panoramic image will be the responsibility of the enrollee.
d) Panoramic images are not considered part of a comprehensive intraoral series.
e) Bitewing images (single radiographic) are limited to once per date of service Bitewing images (two or more radiographic) are limited to once every six (6) months per provider. Bitewing images (four radiographic) are limited to Enrollees age 10 and older.
f) Bitewing images of any type are included in the fee of a comprehensive series when taken within 6 months of the comprehensive images.
g) Image capture procedures are not separately billable services.

(5) Cephalometric images (D0340) and tomographic surveys (D0322) are covered twice (2) in any 12 month period per provider. Diagnostic casts (D0470) are covered only for the evaluation of Orthodontic Services and are provided once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment). See Orthodontic Limitations as age limits may apply. 3D images (D0801 – D0804) are covered once per date of service.

(6) The fee for pulp vitality tests (D0460) is included in the fees for diagnostic (covered codes only between D0100 – D0999), restorative (covered codes only between D2000 – D2999), endodontic (covered codes only between D3000 – D3999) and emergency procedures (D9110) and is not payable separately.

(7) Topical application of fluoride solutions (D1206,D1208) is limited to once in a six (6) month period.

(8) Space maintainer limitations (D1510 – D1575):

a) Except for distal shoe space maintainers (D1575), space maintainers (D1510,D1520) are limited to Enrollees through age 17 and covered once per quadrant in a lifetime, except bilateral space maintiners (D1516, D1517, D1526, D1527) which are covered once per arch.
b) Distal shoe space maintainer - fixed – unilateral (D1575) is limited to children 8 and younger and is limited to once per quadrant per lifetime. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
c) Recementation of space maintainer (D1551, D1552, D1553) is limited to once per provider per applicable arch or quadrant.
d) The removal of a fixed space maintainer (D1556, D1557, D1558) is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(9) Sealants (D1351) are limited as follows:

a) once per tooth per provider every 36 months and only to permanent molars if they are without caries (decay) or restorations on the occlusal surface.

b) repair (D1353) or replacement (D1351) of a Sealant on any tooth within 36 months of its application is included in the fee for the original placement by the original provider.

(10) Delta Dental will not cover replacement of an amalgam (D2140 – D2161), prefabricated crown (D2929 – D2934) or resin-based composite restorations (fillings) (D2330 – D2394) within 12 months of treatment for primary teeth or 36 months of treatment for permanent teeth. Replacement restorations within 12 months for primary teeth and within 24 months for permanent teeth are included in the fee for the original restoration.

(11) Protective restorations (sedative fillings) (D2940) are allowed once per tooth per provider in a six (6) month period when definitive treatment is not performed on the same date of service. The fee for protective restorations are included in the fee for any definitive treatment performed on the same date.

(12) Therapeutic pulpotomy (D3220) is limited to once per tooth per lifetime for baby (deciduous) teeth only; an allowance for an emergency palliative treatment (D9110) is made when performed on permanent teeth.

(13) Pulpal therapy (resorbable filling) (D3230, D3240) for anterior primary teeth and pulpal debridement for primary and permanent teeth (D3221) are limited to once per tooth per lifetime. Retreatment of root canal therapy (D3346 – D3348) by the same Provider/Provider office within 12 months is considered part of the original procedure.

(14) Apexification (D3351 – D3352) is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth with the fee for the final visit included in the fee for the final root canal.

(15) Retreatment of apical surgery (D3410, D3421, D3425, D3426, D3430) by the same Provider/Provider office within 24 months is considered part of the original procedure.

(16) Pin retention (D2951) is covered once per tooth per lifetime for permanent teeth. Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.

(17) Palliative treatment (D9110) is allowed once per date of service per provider regardless of the number of teeth and/or areas treated, and the fee for palliative treatment provided in conjunction with any procedures other than images or select Diagnostic procedures is considered included in the fee for the definitive treatment.

(18) Periodontal limitations (covered codes only between D4000 – D4999):

a) Benefits for periodontal scaling and root planing (D4341, D4342) in the same quadrant are limited to once in every 24-month period for Enrollees age 13 and older.
b) Periodontal surgery (covered codes only between D4210 – D4265) in the same quadrant is limited to once in every 36-month period for Enrollees age 13 and older and includes any surgical re-entry or scaling and root planing (D4341, D4342) performed within 36-months by the same dentist/dental office.
c) Periodontal services, including covered graft procedures are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions (D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250), periradicular surgery (covered codes only between D3410-D3430), ridge augmentation (D7340, D7350, D7950-D7952) or implants (covered codes only between D6010-D6050).
d) Periodontal surgery (covered codes only between D4210 – D4265) is subject to a 30 day wait following periodontal scaling and root planing (D4341, D4342) in the same quadrant.
e) Cleanings (regular and periodontal) (D1110, D1120,D4346, D4910) and full mouth debridement D4355 are subject to a 30 day wait following periodontal scaling and root planing (D4341, D4342) if performed by the same Provider office.
f) When implant procedures (covered codes only between D6000 – D6199) are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure (D6081) is covered as a basic benefit and are limited to once in a 24-month period.

(19) Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth (D7270) are covered once per arch regardless of number of teeth involved for permanent, anterior teeth only.

(20) Surgical repositioning (D7290) of teeth and transseptal fiberotomy/supra crestal fiberotomy (D7291), by report procedures are covered once per arch for permanent teeth for patients in active orthodontic treatment.

(21) Vestibuloplasty - ridge extension (secondary epithelialization) (D7340) is covered once per arch in a five (5) year period. Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) (D7350) is covered once per arch in a lifetime.

(22) Removal of lateral exostosis (maxilla or mandible) (D7471) and of torus madibularis (D7473), as well as the surgical reduction of osseous tuberosity (D7485), are limited to once per quadrant per lifetime. Removal of torus palatinus (D7472) is limited to once per lifetime.

(23) Incision and drainage of abscess – intraoral soft tissue (D7510, D7511) is limited to one (1) per quadrant on the same date of service.

(24) Partial ostectomy/sequestrectomy for removal of non-vital bone (D7550) is limited to on (1) per quadrant on the same date of service.

(25) Palatal lift prosthesis modification (D5959) and speech aid prosthesis modification (D5960) are limited to twice in a 12-month period.

(26) Crowns (covered codes D2710 – D2794), excluding prefabricated crowns (covered codes only between D2929 – D2934), are limited to Enrollees age 13 and older and are covered not more often than once in a five (5) year period except when Delta Dental determines the existing Crown is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues. Services will only be allowed on teeth that are developmentally mature.

(27) Post and core services (covered codes only between D2952 - D2957) are covered once per tooth in a lifetime on permanent teeth.

(28) Crown repairs (D2980) are are not a benefit within 12 months of initial crown placement or previous repair for the same provider.

(29) When allowed within six (6) months of a restoration (D2140-D2161, D2330-D2335, D2391-D2394), the Benefit for a Crown, Inlay/Onlay (covered codes only between D2510 – D2794) or fixed prosthodontic service (covered codes only between D6200- D6999) will be reduced by the Benefit paid for the restoration.

(30) Removable Denture Repairs (D5511, D5512, D5611, D5612, D5621, D5622) are covered once per arch per date of service per provider and not more than twice in any twelve (12) month period per provider. Adding teeth to an existing partial denture (D5650) is covered once per tooth and is limited to a maximum of three (3) per date of service per provider.

(31) Implant services (covered codes only between D6000 – D6199) are a benefit only when exceptional medical conditions are documented and shall be reviewed by the Delta Dental for medical necessity for prior authorization. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. The fee for accessing and retorquing a loose implant screws is included in the fee for the delivery of the implant supported prosthesis, when performed within 6 months of the placement of the prosthesis. Exceptional medical conditions include, but are not limited to:

a) cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.
b) severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.
c) skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).
d) traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.

(32) Fixed partial dentures (bridgework) (D6200 - D6299) are not generally covered but shall be considered for prior authorization only when medical conditions or employment preclude the use of a removable partial denture (covered codes only between D5211 – D5283). The Enrollee shall first meet the criteria for a removable partial denture before a fixed partial denture will be considered. Approved fixed partial dentures are a benefit once in a 60 month period and only for Enrollees age 13 and older.

Medical conditions, which preclude the use of a removable partial denture, include:

a) the epileptic patient where a removable partial denture could be injurious to their health during an uncontrolled seizure,
b) the paraplegia patient who utilizes a mouth wand to function to any degree and where a mouth wand is inoperative because of missing natural teeth,
c) patients with neurological disorders whose manual dexterity precludes proper care and maintenance of a removable partial denture.

(33) Prosthodontics (D5110, D5120, D5211 – D5224, D5863 – D5866) (covered codes only between D6211 – D6791) that were provided under any Delta Dental program will be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Immediate dentures are a benefit once per patient per lifetime. Replacement of a prosthodontic appliance (D5110, D5120, D5211 – D5224, covered codes only between D6211 – D6791) and/or implant supported prosthesis (D6058-D6077, D6094, D6110-D6117) not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Services will only be allowed on teeth that are developmentally mature.

(34) When a posterior fixed bridge (covered codes only between D6205 – D6794) and a removable partial denture (D5211 – D5283) are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(35) Recementation of Crowns, Inlays/Onlays or bridges (D2910, D2915, D2920, D6930) is included in the fee for the Crown, Inlay/Onlay or bridge (covered codes only between D2510 – D2794, D6205 – D6974) when performed by the same Provider/Provider office within 12 months of the initial placement. After 12 months, payment will be limited to one (1) recementation in a 12 month period by the same Provider/Provider office.

(36) TMJ dysfunction procedures are limited to differential diagnosis (covered codes only between D0310-D0322) and symptomatic care (covered codes only between D7810-D7899). Not included as a benefit are those TMJ treatment modalities that involve prosthodontia (D5110, D5120, D5211 – D5224, covered codes only between D6211 – D6791), orthodontia (covered codes only between D8000 – D8999) and full or partial occlusal rehabilitation.

(37) Occlusion analysis – mounted case (D9950), and occlusal adjustments, limited (D9951) and complete (D9952), are limited to one (1) in 12 months for diagnosed TMJ disfunction for permanent dentition and only for Enrollees age 13 and older.

(38) Application of desensitizing medicament (D9951) is limited to once in a 12-month period for permanent teeth only.

(39) Delta Dental limits payment for dentures (covered codes only between D5000 – D5899) to a standard partial (covered codes only between D5211 – D5283) or complete denture (D5110 – D5140) (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments (D5410 – D5422) for the first six (6) months after placement and relines (D5730 – D5761) for the first 12 months after placement.

a) Dentures, removable partial dentures (D5211 – D5283) and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment, adjustments are limited to twice in a 12 month period per provider and relining is limited to once in a 12 month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to twice in a 12 month period and relining is limited to once in a 12 month period.
b) Tissue conditioning (D5850, D5851) is limited to two (2) per prosthesis in a 36 month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline service.
c) Recementation of fixed partial dentures (D6930) is not a benefit within 12 months of a previous re-cementation by the same provider.

(40) Limitations on Orthodontic Services (covered codes only between D8000 – D8999):

a) Services are limited to medically necessary orthodontics when provided by a Provider. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained.
b) Orthodontics, including oral evaluations and all treatment, must be performed by a licensed dentist or their 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. 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.
c) Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.

d) The automatic qualifying conditions are:
   i) Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
   ii) Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
   iii) A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
   iv) A crossbite of individual anterior teeth causing destruction of soft tissue,
   v) An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
   vi) Severe traumatic deviation.
e) The following documentation must be submitted with the request for prior authorization of services by the Provider:
   i) ADA 2006 or newer Claim Form with service code(s) requested;
   ii) Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
   iii) Cephalometric radiographic image or panoramic radiographic image;
   iv) HLD score sheet completed and signed by the Orthodontist; and
   v) Treatment plan.
f) The allowances for comprehensive orthodontic treatment procedures (D8080) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention) (D8680). No additional charge to the Enrollee is permitted.
g) Comprehensive orthodontic treatment (D8080) includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.
h) Orthodontic procedures are Benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Enrollees under the age of 19 and shall be prior authorized.
i) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Enrollee is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
j) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
k) Pre-orthodontic treatment visits (D8660) are allowed once every three (3) months up to a maximum of six (6) per Enrollee.
l) Removable and fixed appliance therapy (D8210, D8220) are allowed once per Enrollee age six (6) to 12.
m) When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided (covered codes only between D8000-D8999), Delta Dental will make an allowance for the cost of a standard orthodontic treatment. The Enrollee is responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist's charge for the specialized orthodontic appliance or procedure.
n) Repair of an orthodontic appliance (D8696, D8697) inserted under this dental plan is covered once per appliance. The replacement of an orthodontic appliance inserted under this dental plan is covered once per arch.
o) Replacement of a lost or broken retainer (D8703, D8704) is a benefit once per arch and only within 24 months following date of service of orthodontic retention.
p) The removal of fixed orthodontics appliances (D8695) for reasons other than completion of treatment is not a covered benefit.

(41) The fees for synchronous/asynchronous Teledentistry services are considered inclusive in overall patient management and are not separately payable services.

Exclusions for Pediatric Benefits (under age 19)

Delta Dental does not pay Benefits for:

(1) services that are not Essential Health Benefits except as required by state or federal law.

(2) treatment of injuries or illness covered by workers' compensation or employers' liability laws;services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(3) cosmetic surgery or procedures for purely cosmetic reasons (D9972-D9975, D2960-D2962), (exclude covered codes in this list if done for purely cosmetic reasons: D2710–D2751, D2940, D2330–D2394, D8000-D8999).

(4) provisional and/or temporary restorations (D2799). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.

(5) treatment to stabilize teeth (D7272), treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: periodontal splinting (D4322, D4323) or fixed bridge procedures (D6252–D6720).

(6) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(7) pain killers or experimental/investigational procedures.

(8) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia (D9215) and regional/or trigeminal bloc anesthesia (D9211/D9212) are not separately payable procedures.

(9) extraoral grafts (grafting of tissues from outside the mouth to oral tissues) (D4263, D4264).

(10) laboratory processed crowns for Enrollees under age 13 (D2710, D2712, D2721, D2740, D2751, D2781, D2783, D2791).

(11) interim implants (D6012, D6051, D6118, D6119) and endodontic endosseous implants (D3460).

(12) indirectly fabricated resin-based Inlays/Onlays (D2650 - D2664).

(13) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(14) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(15) charges incurred for oral hygiene instruction (D1330), a plaque control program, preventive control programs including home care times, dietary instruction, image duplications, cancer screening, tobacco counseling (D1320) or broken appointments (D9986) are not separately payable procedures.

(16) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(17) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(18) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.

(19) Deductibles and/or any service not covered under the dental plan.

(20) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(21) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided a prior authorization is obtained (D8000-D8999).

(22) Missed (D9986) and/or cancelled (D9987) appointments.

(23) action taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

(24) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

(25) dental case management motivational interviewing and patient education to improve oral health literacy.

(26) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

(27) diabetes testing.

(28) corticotomy (specialized oral surgery procedures associated with orthodontics) (D7296, D7297).

(29) antigen or antibody testing.

(30) services or supplies for sleep apnea.

Attachment C
Information Concerning Benefits for Delta Dental Individual & Family™

Delta Dental PPO™
Family Dental PPO

THIS MATRIX IS INTENDED TO BE USED TO COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE COMBINED POLICY AND DISCLOSURE FORM SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PLAN BENEFITS AND LIMITATIONS.

ADULTS (AGE 19 AND OLDER)		
	Delta Dental PPO Providers[2]	**Delta Dental Premier® and Non-Delta Dental Providers[2]**
(A) Deductibles[1] **per Enrollee** **per Family**	 $50 each Calendar Year None	 $50 each Calendar Year None
(B) Lifetime Maximum per Enrollee	$1,500 each Calendar Year	
(C) Annual Out-of-Pocket Maximum	None	
(D) Professional Services	**Policy Benefit Levels**	
Dental Service Category:		
Delta Dental will pay or otherwise discharge the Policy Benefit Levels according to the Maximum Contract Allowance for the following services:		
Diagnostic and Preventive Services	100%	90%
Basic Services	80%	70%
Major Services[3]	50%	50%
Medically Necessary Orthodontic Services	Not a covered benefit	Not a covered benefit
(E) Outpatient Services	Not Covered	
(F) Hospitalization Services	Not Covered	
(G) Emergency Dental Coverage	Benefits for Emergency Dental Services by a Non-Delta Dental Provider are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.	
(H) Ambulance Services	Not Covered	
(I) Prescription Drug Coverage	Not Covered	
(J) Durable Medical Equipment	Not Covered	
(K) Mental Health Services	Not Covered	
(L) Chemical Dependency Services	Not Covered	
(M) Home Health Services	Not Covered	
(N) Other	Not Covered	

[1] The annual Deductible is waived for Diagnostic and Preventive Services.

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

[3] Major Services are limited to Adult Enrollees who have been enrolled in the Policy for six consecutive months. The six month Waiting Period for Major Services must be waived upon Enrollee's proof of prior comparable dental coverage. This Waiting Period will be prorated on a one to one monthly basis upon Enrollee's proof of prior comparable dental coverage of less than six months. Covered California leaves it to the plan to determine acceptable documentation to verify prior proof of coverage. Covered California leaves it to the plan to determine the maximum allowable gap in coverage before proration of the six month Waiting Period would no longer occur. Dental services obtained via a discount health plan are not considered "comparable" dental coverage for purposes of counting towards the Waiting Period.

PEDIATRIC (UNDER AGE 19)		
	Delta Dental PPO Providers[2]	**Delta Dental Premier and Non-Delta Dental Providers[2]**
(A) Deductibles[1] **per Enrollee** **per Family**	 $75 each Calendar Year $150 each Calendar Year	 $75 each Calendar Year $150 each Calendar Year
(B) Lifetime Maximums per Enrollee	None	None
(C) Annual Out-of-Pocket Maximum* **Pediatric Enrollee** **Multiple Pediatric Enrollees**	 $350 each Calendar Year $700 each Calendar Year	 None None
(D) Professional Services	**Policy Benefit Levels**	
Dental Service Category:		
Delta Dental will pay or otherwise discharge the Policy Benefit Levels according to the Maximum Contract Allowance for the following services:		
Diagnostic and Preventive Services	100%	90%
Basic Services	80%	70%
Major Services	50%	50%
Medically Necessary Orthodontic Services	50%	50%
(E) Outpatient Services	Not Covered	
(F) Hospitalization Services	Not Covered	
(G) Emergency Dental Coverage	Benefits for Emergency Dental Services by a Non-Delta Dental Provider are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.	
(H) Ambulance Services	Not Covered	
(I) Prescription Drug Coverage	Not Covered	
(J) Durable Medical Equipment	Not Covered	
(K) Mental Health Services	Not Covered	
(L) Chemical Dependency Services	Not Covered	
(M) Home Health Services	Not Covered	
(N) Other	Not Covered	

[1] The annual Deductible is waived for Diagnostic and Preventive Services.

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

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

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

POLICY VARIABLES

Policyholder:

Effective Date:

Policy Year:

Policy ID Number:

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

Monthly Premium:

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.

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)

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)

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)

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)

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)

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)

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)

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)

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)

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)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-866-530-9675 (TTY: 711). (Hmong)

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

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

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