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This is Your

PREFERRED PROVIDER ORGANIZATION CONTRACT

Issued by

Delta Dental of New York, Inc.
150 East 58th St, 24 Fl
New York, NY 100155

This is Your individual Contract for preferred provider organization coverage issued by Delta Dental of New York, Inc. This Contract, together with the attached Schedule of Benefits, applications, and any amendment or rider amending the terms of this Contract, constitute the entire agreement between You and Us.

You have the right to return this Contract. Examine it carefully. If You are not satisfied, You may return this Contract to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Contract. We will refund any Premium paid including any Contract fees or other charges.

Renewability. The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Contract or by the Subscriber upon 30 days' prior written notice to Us.

This Contract offers You the option to receive Covered Services on two benefit levels:

1. **In-Network Benefits.** In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers in Our Delta Dental PPO™ Network. You should always consider receiving dental care services first through the in-network benefits portion of this Contract.

2. **Out-of-Network Benefits.** The out-of-network benefits portion of this Contract provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge.

READ THIS ENTIRE CONTRACT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

This Contract is governed by the laws of New York State.

This Contract has no waiting periods imposed on benefits.

The insurance evidenced by this Contract provides DENTAL insurance ONLY.

Michael G. Hankinson, EVP, Chief Legal and Compliance Officer

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SECTION I. Definitions

Defined terms will appear capitalized throughout the Contract.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Contract for a description of how the Allowed Amount is calculated. If Your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Contract.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Contract: This Contract issued by Delta Dental of New York, Inc., including the Schedule of Benefits and any attached riders.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Contract.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

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

Delta Dental Premier Provider ("Premier Provider"): A Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental Premier Contracted Fee as payment in full for services

provided under a plan. A Premier Provider also agrees to comply with Delta Dental's administrative guidelines. Delta Dental Premier Provider are considered Non-Participating Providers.

Dependents: The Subscriber's Spouse and Children. Additional Dependents are also described in the Who is Covered section of this Policy.

Emergency Dental Care: Emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Refer to the Pediatric Dental Care section of this Contract for details.

Exclusions: Dental care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

In-Network Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider. The amount can vary by the type of Covered Service.

In-Network Cost-Sharing: Amounts You must pay to a Participating Provider for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Medically Necessary: See the How Your Coverage Works section of this Contract for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice, "Member" also means the Member's designee.

Network: The Providers We have contracted with to provide health care services to You.

New York State of Health ("NYSOH"): The New York State of Health, the Official Health Plan Marketplace. The NYSOH is a marketplace for health insurance where individuals, families and small businesses can learn about their health insurance options; compare plans based on cost, benefit and other important features; apply for and receive financial help with premiums and cost-sharing based on income; choose a plan; and enroll in coverage. The NYSOH also helps eligible consumers enroll in other programs including Medicaid, Child Health Plus, and the Essential Plan.

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 Delta Dental's administrative guidelines. Non-Delta Dental Providers are considered Non-Participating Providers.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide health care services to You. You will pay more to see a Non-Participating Provider.

Out-of-Network Coinsurance: Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service that You are required to pay to a Non-Participating Provider. The amount can vary by the type of Covered Service.

Out-of-Network Cost-Sharing: Amounts You must pay to a Non-Participating Provider for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of dental care services We do not Cover. The Out-of-Pocket Limit only applies to benefits that are part of the pediatric dental essential health benefit.

Participating Provider: A Provider who has a contract with Us to provide health care services to You. A list of Participating Providers and their locations is available on Our website at deltadentalins.com or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year A calendar year ending on December 31 of each year.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, or device that the Covered Service, procedure, treatment plan, or device is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Contract.

Premium: The amount that must be paid for Your dental insurance coverage.

Premium Tax Credits: Financial help that lowers Your taxes to help You and Your family pay for private dental insurance. You can get this help if You get health insurance through the NYSOH and Your income is below a certain level. Advance payments of the tax credit can be used right away to lower Your monthly Premium.

Primary Care Dentist ("PCD"): A participating dentist who directly provides or coordinates a range of dental services for You.

Provider: An appropriately licensed, registered or certified dentist, dental hygienist, or dental assistant under Title 8 of the New York State Education Law (or other comparable state law, if applicable) that the New York State Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Provider's services must be rendered within the lawful scope of practice for that type of Provider in order to be Covered under the Contract.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCD to a Specialist) in order to arrange for additional care for a Member.

Schedule of Benefits: The section of this Contract that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Pre-authorization requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: all counties within New York State.

Specialist: A dentist who focuses on a specific area of dentistry, including oral surgery, endodontia, periodontia, orthodontia and pediatric dentistry, or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse. Spouse also includes a domestic partner.

Subscriber: The person to whom this Contract is issued.

UCR (**Usual, Customary and Reasonable):** The amount paid for a dental service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Us, We, Our: Delta Dental of New York, Inc. and anyone to whom We legally delegate performance, on Our behalf, under this Contract.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II. How Your Coverage Works

A. Your Coverage under this Contract.

You have purchased a dental insurance Contract from Us. We will provide the benefits described in this Contract to You and/or Your covered Dependents. You should keep this Contract with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Contract only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider for in-network coverage;
- Listed as a Covered Service;

- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Contract; and
- Received while Your Contract is in force.

C. Participating Providers.

Delta Dental PPO Providers are considered Participating Providers under this plan. Premier and Non-Delta Dental Providers are considered Non-Participating Providers. Non Participating Providers have not agreed to the features of the PPO plan. Therefore, You may be balanced billed up to the Premier Provider's Contracted Fee or the Non-Delta Dental Provider's submitted fee. To take full advantage of Your dental plan, we highly recommend You verify a dentist's participation status with Your dental office before each appointment. Review the section titled "Cost-Sharing Expenses and Allowed Amount Section" for an explanation of payment procedures to understand the method of payments applicable to Your dentist selection and how that may impact Your out-of-pocket costs.

To find out if a Provider is a Delta Dental PPO Provider (Participating Provider):

- Check Our Provider directory, available at Your request.
- Call 888-857-0314 and one of our representatives will assist You. We can provide You with information regarding a Provider's network, specialty and office location; or.
- Visit our website at deltadentalins.com. This website includes a Provider search function allowing You to locate PPO Providers by location, specialty and network type.

To find out if a Provider is a Delta Dental Premier Provider (Non-Participating Provider):

- Check Our Provider directory, available at Your request.
- Call 888-857-0314 and one of our representatives will assist You. We can provide You with information regarding a Provider's network, specialty and office location; or.
- Visit our website at deltadentalins.com. This website includes a Provider search function allowing You to locate Premier Providers by location, specialty and network type.

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken; and
- Whether the Participating Provider is accepting new patients.

D. The Role of Primary Care Dentists.

This Contract does not have a gatekeeper, usually known as a Primary Care Dentist ("PCD"). You do not need a Referral from a PCD before receiving Specialist care

E. Out-of-Network Services.

We Cover the services of Non-Participating Providers. See the Schedule of Benefits section of this Contract for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

F. Services Subject To Preauthorization.

Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the in-network and out-of-network services listed in the Schedule of Benefits section of this Contract.

G. Access to Providers and Changing Providers.
Sometimes Providers in Our Provider directory are not available. You should call the Provider to make sure he or she is a Participating Provider and is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are a Delta Dental PPO Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Member ID number. When You go to the Provider's office, bring Your ID card with You.

To contact Your Provider after normal business hours, call the Provider's office. You will be directed to Your Provider, an answering machine with directions on how to obtain services, or another Provider. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve a Referral to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

H. Preauthorization Procedure.
If You seek coverage for services that require Preauthorization, You must call Us at 888-857-0314. You must contact Us to request Preauthorization at least two (2) weeks prior to a planned service. If that is not possible, then contact Us as soon as reasonably possible during regular business hours prior to the service.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources including medical policy, clinical guidelines, and therapeutic guidelines.

I. Pre-Determination/Pre-Treatment Estimates.
We allow You to request and obtain an estimate of coverage. You or Your Provider may contact Us and request a pre-determination of benefits, also known as a pre-treatment estimate. If We determine that an alternative procedure or treatment is more appropriate than the requested service, You may appeal Our decision through an internal Appeal or external appeal. See the Utilization Review and External Appeal sections of this Contract for Your right to an internal Appeal and external appeal.

J. Medical Management.
The benefits available to You under this Contract may be subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

K. Medical Necessity.
We Cover certain benefits described in this Contract as long as the dental service, procedure, treatment, test, device, or supply (collectively, "service") is Medically Necessary e.g. procedures such as laboratory processed crowns, periodontal surgical services, orthodontics, fixed prosthodontic services, and implant procedures. The fact that a Provider

has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your dental records;
- Our dental policies and clinical guidelines;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of health care professionals in the generally-recognized health specialty involved.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of dental practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services that is at least as likely to produce equivalent therapeutic or diagnostic results.

See the Utilization Review and External Appeal sections of this Contract for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

L. Important Telephone Numbers and Addresses.

- CLAIMS
  888-857-0314
  Delta Dental of New York, Inc.
  P.O. Box 2105
  Mechanicsburg, PA 17055-2105 or
  (Submit claims forms to this address.)

  deltappoclaims@delta.org
  (Submit electronic claim forms to this e-mail address.)

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  888-857-0314

- MEMBER SERVICES
  888-857-0314
  (Member Services Representatives are available Monday – Friday 8:00 a.m. – 5:00 p.m.)

- PREAUTHORIZATION
  888-857-0314

- OUR WEBSITE
  deltadentalins.com

SECTION III. Cost-Sharing Expenses and Allowed Amount

A. Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Contract for Covered in-network and out-of-network Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Contract. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Contract collectively total the family Deductible amount in the Schedule of Benefits section of this Contract in a Plan Year, no further Deductible will be required for any person covered under this Contract for that Plan Year. Cost-Sharing amounts incurred with Participating and Non-Participating Providers accumulate to the Deductible.

You have a combined In-Network and Out-of-Network Deductible. Amounts You pay for out-of-network services apply towards Your In-Network Deductible. Amounts You pay for in-network services apply toward Your Out-of-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible.**

The Deductible runs from January 1 to December 31 of each calendar year.

B. Copayments.

There are no Copayments for Covered Services under this Contract.

C. Coinsurance.

Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network or out-of-network benefit as shown in the Schedule of Benefits section of this Contract. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

D. In-Network Out-of-Pocket Limit for the Pediatric Dental Essential Health Benefit.

When You have met Your In-Network Out-of-Pocket Limit in payment of In-Network Cost-Sharing for a Plan Year in the Schedule of Benefits section of this Contract for the pediatric dental essential health benefit, We will provide coverage for 100% of the Allowed Amount for Covered in-network Services for the remainder of that Plan Year for the pediatric dental essential health benefit. If you have other than individual coverage, the individual In-Network Out-of-Pocket Limit applies to each Member under age 19 covered under this Contract. Once a Member under age 19 meets the In-Network Out-of-Pocket Limit for one (1) Member under age 19, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person for the pediatric dental essential health benefit. If this Contract covers more than one Member under age 19, when two (2) or more Members under age 19 covered under this Contract have collectively met the In-Network Out-of-Pocket Limit for two (2) or more Members under age 19 in payment of In-Network Cost-Sharing for a Plan Year in the Schedule of Benefits section of this Contract, We will provide coverage for 100% of the Allowed Amount for the pediatric dental essential health benefit for the rest of that Plan Year.

Cost-Sharing for out-of-network services, except for our out-of-network services approved by Us as an in-network exception does not apply toward Your In-Network Out-of-Pocket Limit. The In-Network Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.

E. Out-of-Network Out-of-Pocket Limit for the Pediatric Dental Essential Health Benefit.
This Contract does not have an Out-of-Network Out-of-Pocket Limit on the pediatric dental essential health benefit.

F. Out-of-Network Out-of-Pocket Limit.
This Contract does not have an Out-of-Network Out-of-Pocket Limit on benefits other than the pediatric dental essential health benefit.

G. In-Network Annual Maximum.
This Contract has an in-network and out-of-network annual maximum for in-network and out-of-network benefits described in the Adult Dental Care section of this Contract. There is no annual maximum for the in-network and out-of-network pediatric dental essential health benefit. When Members receiving adult dental care have met the in-network and out-of-network annual maximum for in-network Covered Services in the Schedule of Benefits section of this Contract, no more benefits will be payable for that Member for the remainder of that Plan Year. If You have other than individual coverage, the individual in-network annual maximum for adult dental care benefits applies to each person covered under this Contract. Once a person within a family meets the individual in-network annual maximum for adult dental care, no more benefits for services will be payable for that person.

H. Out-of-Network Annual Maximum.
This Contract has an out-of-network annual maximum for out-of-network benefits. There is no annual maximum for the in-network pediatric dental essential health benefit. Once You have met the out-of-network annual maximum for out-of-network Covered Services in the Schedule of Benefits section of this Contract, no more benefits will be payable for the remainder of that Plan Year. If You have other than individual coverage, the individual out-of-network annual maximum applies to each person covered under this Contract. Once a person within a family meets the individual out-of-network annual maximum, no more benefits will be payable for that person.

I. Your Additional Payments for Out-of-Network Benefits.
When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductible and Coinsurance described in the Schedule of Benefits section of this Contract, You must also pay the amount, if any, by which the Non-

Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any Cost-Sharing amounts You pay may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one inclusive payment in that case, rather than a separate payment for each billed code.

J. Allowed Amount.
"Allowed Amount" means the maximum amount We will pay for the services or supplies covered under this Contract, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider, or the Participating Provider's charge, if less.

The Allowed Amount for Non-Participating Providers will be100% of an amount based on Our Participating Provider fee schedule or rate.

Our Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge. Contact Us at 888-857-0314 for information on Your financial responsibility when You receive services from a Non-Participating Provider.

K. Payment for Services.
Please note: if a Provider is a Premier Provider who has not agreed to the features of the PPO plan or is a Non-Delta Dental Provider, the amount charged to Members may be more than the amount accepted by PPO Providers, and members will be responsible for balance billed amounts.

1. **Participating Providers.**
   PPO Provider. Payment for covered services performed by a PPO Provider is calculated based on the Allowed Amount. PPO Providers have agreed to accept the Delta Dental PPO Contracted Fee for covered services. PPO Providers will not balance bill you for any amount above the Delta Dental PPO Contracted fee.

   Our payment is sent directly to the PPO provider who submitted your claim. We advise You of any charges not payable by Us for which You are responsible. These charges are generally Your share of the Allowed Amount, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

2. **Non-Participating Providers.**
   Premier Provider. Payment for covered services performed for You by a Premier Provider is calculated based on the Allowed Amount. Premier Providers may balance bill for the difference between the Delta Dental Premier Contracted Fee and the Delta Dental PPO Contracted Fee.

   Our payment is send directly to the Premier Provider who submitted the claim. We will advise You of any charges not payable by us for which You are responsible. These charges are generally Your share of the Allowed Amount, as well as any Deductibles, charges where the maximum has been exceeded, charges for non-covered services and/or balance billing amounts over the Delta Dental PPO Contracted Fee.

   Non-Delta Dental Provider. Payment for services performed by a Non-Delta Dental Provider is calculated based on the Allowed Amount. Non-Delta Dental Providers have no agreement with Us and may bill You for any difference between what We pay and the Submitted Fee.

   When dental services are received from a Non-Delta Dental Provider, Delta Dental's payment is sent directly to the Member. You are responsible for payment of the Non-Delta Dental Provider's Submitted Fee. Non-Delta Dental Providers will bill You for their normal charges, which may be higher than the Allowed Amount for the service. You may be required to pay the Provider Yourself and then submit a claim to Us for reimbursement. Since Our payment for services You receive may be less than the Non-Delta Dental Provider's actual charges, Your out-of-pocket cost may be significantly higher. We advise You of any charges not payable by Us for which You are responsible.

These charges are generally Your share of the Allowed Amount, as well as any Deductibles, charges where the maximum has been exceeded and/or charges for non-covered services.

SECTION IV. Who Is Covered

A. Who is Covered Under this Contract.

You, the Subscriber to whom this Contract is issued, are covered under this Contract. You must live or reside in Our Service Area to be covered under this Contract. Members of Your family may also be covered depending upon the type of coverage You selected.

B. Types of Coverage.

We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.

2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.

3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.

4. **Family.** If You selected family coverage, then You, Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under This Contract.

If You selected parent and child/children or family coverage, Children covered under this Contract include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Grandchildren who are chiefly dependent upon You for support and Foster Children are covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, intellectual disability (as defined in the New York Mental Hygiene Law), or physical disability and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child qualifies and continues to qualify under this section.

Coverage shall continue for a Child who is a full-time student when the Child takes a medical leave of absence from school due to illness for a period of 12 months from the last day of attendance in school. However, coverage of the Child is not provided beyond the age at which coverage would otherwise terminate. To qualify for such coverage, We may require that the leave be certified as Medically Necessary by the Child's Physician who is licensed to practice in the state of New York.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Contract at any time.

D. Special Enrollment Periods

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child, can enroll for coverage within 60 days prior to or after the occurrence of one of the following events:

1. You or Your Spouse or Child involuntarily lose minimum essential coverage, including COBRA, including if You are enrolled in a non-calendar year group health plan or individual health insurance coverage, even if You have the option to renew the coverage;
2. You, Your Spouse or Child are determined newly eligible for advance payments of the Premium Tax Credit because coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, including as a result of Your employer discontinuing or changing available coverage within the next 60 days, provided that You are allowed to terminate existing coverage;
3. You, Your Spouse or Child lose eligibility for Medicaid coverage, including Medicaid coverage for pregnancy-related services and Medicaid coverage for the medically needy, but not including other Medicaid programs that do not provide coverage for primary or specialty care;
4. You, Your Spouse or Child move and become eligible for new qualified dental plans because of a permanent move and You, Your Spouse or Child had minimum essential coverage for one (1) or more days during the 60 days before the move; or
5. You, Your Spouse or Child are no longer incarcerated.

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child, can enroll for coverage within 60 days after the occurrence of one (1) of the following events:

1. You, Your Spouse or Child's enrollment or non-enrollment in another qualified dental plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the NYSOH, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by the NYSOH.
2. You, Your Spouse or Child adequately demonstrate to the NYSOH that another qualified dental plan in which You were enrolled substantially violated a material provision of its contract;
3. You gain a Dependent or become a Dependent through birth, adoption or placement for adoption, or placement in foster care or through a child support order or other court order;
4. You gain a Dependent or become a Dependent through marriage and You or Your Spouse had minimum essential coverage for one (1) or more days during the 60 days before the marriage;
5. You lose a Dependent or are no longer considered a Dependent through divorce, legal separation, or upon the death of You or Your Dependents;
6. If You are an Indian, as defined in 25 U.S.C. 450b(d), You and Your Dependents may enroll in a qualified dental plan or change from one (1) qualified dental plan to another one (1) time per month;

7. You, Your Spouse or Child demonstrate to the NYSOH that You meet other exceptional circumstances as the NYSOH may provide;
8. You, Your Spouse or Child were not previously a citizen, national, or lawfully present individual and You gain such status;
9. You, Your Spouse or Child are determined newly eligible or newly ineligible for advance payments of the Premium Tax Credit or have a change in eligibility for cost-sharing reductions;
10. You are a victim of domestic violence or spousal abandonment, including a Dependent or unmarried victim within a household, are enrolled in minimum essential coverage, and You and Your Dependents seek to enroll in coverage separate from the perpetrator of the abuse or abandonment;
11. You, Your Spouse or Child apply for coverage during the annual open enrollment period or due to a qualifying event, are assessed by the NYSOH as potentially eligible for Medicaid or Child Health Plus, but are determined ineligible for Medicaid or Child Health Plus after open enrollment has ended or more than 60 days after the qualifying event; or
12. You, Your Spouse or Child adequately demonstrate to the NYSOH that a material error related to plan benefits, service area, or premium influenced Your decision to purchase a qualified dental plan through the NYSOH

The NYSOH must receive notice and We must receive any Premium payment within 60 days of one (1) of these events.

If You, Your Spouse or Child enroll because You are losing minimum essential coverage within the next 60 days, You are determined newly eligible for advance payment of the Premium Tax Credit because the coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, or You gain access to new qualified health plans because You are moving, and Your selection is made before the triggering event, then Your coverage will begin on the first day of the month following Your loss of coverage.

If You, Your Spouse or Child are applying due to a permanent move or marriage, You, Your Spouse or Child can meet the requirement to demonstrate coverage in the 60 days prior to the permanent move or marriage by having minimum essential coverage for one (1) or more days during the 60 days before the move or marriage; living in a foreign country or in a United States territory for one (1) or more days during the 60 days before the move or marriage; You are an Indian as defined in 25 U.S.C. 450b(d); or You lived for one (1) or more days during the 60 days before the move or marriage in a service area where no qualified health plan was available through the NYSOH.

E. Effective Dates of Coverage for Special Enrollment Periods.
If You, Your Spouse or Child enroll because You got married, Your coverage will begin on the first day of the month following Your selection of coverage. If You, Your Spouse or Child enroll because You gain a Dependent through adoption or placement for adoption, Your coverage will begin on the date of the adoption or placement for adoption. If You, Your Spouse or Child enroll because of a court order, Your coverage will begin on the date the court order is effective.

If You have a newborn or adopted newborn Child and the NYSOH receives notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which the NYSOH receives notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition

pursuant to Section 115-c of the New York Domestic Relations Law within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. If You have individual or individual and Spouse coverage You must also notify the NYSOH of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which the NYSOH receives notice, provided that You pay any additional Premium when due.

Advance payments of any Premium Tax Credit are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month.

If You, Your Spouse or Child enroll because of the death of You or Your Dependents, Your coverage will begin on the first day of the month following Your selection.

In all other cases, the effective date of Your coverage will depend on when the NYSOH receives Your selection. If Your selection is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is received by then. If Your selection is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month, as long as Your applicable Premium payment is received by then.

F. Domestic Partner Coverage.
This Contract covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under this Contract also includes the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or
2. For partners residing where registration does not exist, by:
   - **a.** An alternative affidavit of domestic partnership. The affidavit must be notarized and must contain the following:
     - The partners are both 18 years of age or older and are mentally competent to consent to contract;
     - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
     - The partners have been living together on a continuous basis prior to the date of the application; and
     - Neither individual has been registered as a member of another domestic partnership within the last six (6) months;
   - **b.** Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
   - **c.** Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
     - A joint bank account;
     - A joint credit card or charge card;
     - Joint obligation on a loan;
     - Status as an authorized signatory on the partner's bank account, credit card or charge card;
     - Joint ownership of holdings or investments;
     - Joint ownership of residence;

- Joint ownership of real estate other than residence;
- Listing of both partners as tenants on the lease of the shared residence;
- Shared rental payments of residence (need not be shared 50/50);
- Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
- A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
- Shared household budget for purposes of receiving government benefits;
- Status of one (1) as representative payee for the other's government benefits;
- Joint ownership of major items of personal property (e.g., appliances, furniture);
- Joint ownership of a motor vehicle;
- Joint responsibility for child care (e.g., school documents, guardianship);
- Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
- Execution of wills naming each other as executor and/or beneficiary;
- Designation as beneficiary under the other's life insurance policy;
- Designation as beneficiary under the other's retirement benefits account;
- Mutual grant of durable power of attorney;
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION V. Pediatric Dental Care

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover the following dental care services for Members through the end of the month in which the Members turn 19 years of age:

A. **Emergency Dental Care.** We Cover Emergency Dental Care, which includes emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency Dental Care is not subject to Our Preauthorization.

B. **Preventive Dental Care.** We Cover preventive dental care that includes procedures which help to prevent oral disease from occurring, including:
   - Prophylaxis (scaling and polishing the teeth) two (2) times per Plan Year;
   - Topical fluoride application two (2) times per Plan Year where the local water supply is not fluoridated;
   - Sealants on unrestored permanent molar teeth; and
   - Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

C. **Routine Dental Care.** We Cover routine dental care provided in the office of a dentist, including:
   - Dental examinations, visits and consultations two (2) times per Plan Year;

- X-rays, full mouth x-rays or panoramic x-rays at 36 month intervals, bitewing x-rays at six (6) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation;
- Amalgam, composite restorations and stainless steel crowns; and
- Other restorative materials appropriate for children.

D. Endodontics. We Cover routine endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

E. Periodontics. We Cover limited periodontic services. We Cover non-surgical periodontic services. We Cover periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects. We also Cover periodontic services in anticipation of, or leading to orthodontics that are otherwise Covered under this Contract.

F. Prosthodontics. We Cover prosthodontic services as follows:

- Removable complete or partial dentures, for Members 15 years of age and above, including six (6) months follow-up care;
- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate; and
- Interim prosthesis for Members five (5) to 15 years of age.

We do not Cover implants or implant related services.

Fixed bridges are not Covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

G. Oral Surgery. We Cover non-routine oral surgery, such as partial and complete bony extractions, tooth re-implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of device to facilitate eruption of an impacted tooth. We also Cover oral surgery in anticipation of, or leading to orthodontics that are otherwise Covered under this Contract.

H. Orthodontics. We Cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);

- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

SECTION VI. Adult Dental Care

Coverage for pediatric benefits lasts until the end of the month in which the Member turns 19 years of age. The Member is transitioned to the adult benefit when the pediatric benefits end. Coverage for Children under the adult benefit lasts until the end of the month in which the Child turns 26 years of age.

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

We will pay Benefits only for covered services. This Policy covers several categories of Benefits when a Provider furnishes the services and when they are necessary and within the standards of generally accepted dental practice. Claims shall 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.

We will pay or otherwise discharge the Cost-Sharing shown in the Schedule of Benefits section of this Contract for the following services:

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

2. Basic Services
   - Palliative: emergency treatment to relieve pain.
   - 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).

3. Temporomandibular Joint (TMJ) Dysfunction Services
   Intra-oral services provided by a Provider, when necessary and customary according to the standards of generally accepted dental practice, for treatment of acute dental symptoms associated with myofacial pain dysfunction or malfunction of the temporomandibular (jaw) joint (TMJ).

4. Note on additional Benefits during pregnancy
   When a Member is pregnant, We will pay for additional services to help improve the oral health of the Member during the pregnancy. The additional services each Plan Year while the Member is covered under this Contract include one (1) additional oral exam and one (1) additional routine cleaning. Written confirmation of the pregnancy must be provided by the Member or her Provider when the claim is submitted.

B. Limitations for Adult Benefits (age 19 and older)

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

If a Member receives optional services, an alternate benefit will be allowed, which means We will base benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the optional service. The Member 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. We will pay for oral examinations (except after hours exams and exams for observation) and routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) no more than twice in a Plan Year**.** See note on additional benefits during pregnancy.

3. A caries risk assessment is allowed once in 12 months.

4. Application of caries arresting medicament is limited to twice per tooth per Calendar Year.

5. X-ray 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) Panoramic images are not considered part of a comprehensive intraoral series.
   c) If a panoramic image is taken in conjunction with an intraoral 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) Benefits are limited to either one (1) comprehensive intraoral series or one (1) panoramic image once every 60 months.
   e) Bitewing images are limited to one (1) time each Plan Year. Bitewings of any type are not billable to the Enrollee or Delta Dental within 6 months of a full mouth series unless warranted by special circumstances.
   f) Image capture procedures are not separately allowable services.

6. Pulp vitality tests are allowed once per day when definitive treatment is not performed.

7. Screening 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.

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

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

10. Pin retention is covered not more than once in any 24-month period.

11. Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required images or select diagnostic procedures.

12. The fees for synchronous/asynchronous teledentistry services are considered inclusive in overall patient management and are not a separately payable service.

13. Limitations on TMJ Services:
    a) TMJ benefits are subject to all the limitations, exclusions and other terms and conditions in this Contract.
    b) We will not pay for the replacement of any appliance furnished in whole or in part under this Contract or any other health plan which provides TMJ benefits.
    c) Benefits are limited to: those intra-oral services which would normally be provided by a Provider in relief of oral symptoms associated with TMJ and will not include those services which would normally be provided under medical care including, but not limited to, psychotherapy, special joint exams and x-rays, joint surgery and medications.
    d) Fixed appliances and restorations are excluded. Diagnostic procedures not otherwise covered under this Contract are excluded.
    e) Any procedure paid under any other category of benefits by this Contract is not covered as a TMJ benefit.

SECTION VII. Exclusions and Limitations

No coverage is available under this Contract for the following:

A. Cosmetic Services.

We do not Cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect, except for pediatric orthodontics as described in the Pediatric Dental Care section of this Contract. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Contract unless medical information is submitted.

B. Coverage Outside of the United States, Canada or Mexico.

We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Dental Care as described in the Pediatric Dental Care section of this Contract.

C. Experimental or Investigational Treatment.

We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Contract for non-investigational treatments. See the Utilization Review and External Appeal sections of this Contract for a further explanation of Your Appeal rights.

D. Felony Participation.

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.

E. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

F. Medical Services.
We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

G. Medically Necessary.
In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device is otherwise Covered under the terms of this Contract.

H. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

I. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the armed forces or auxiliary units.

J. No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

K. Services not Listed.
We do not Cover services that are not listed in this Contract as being Covered.

L. Services Provided by a Family Member.
We do not Cover services performed by a covered person's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

M. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

N. Services with No Charge.
We do not Cover services for which no charge is normally made.

O. War.
We will not Cover an illness, treatment or medical condition due to war, declared or undeclared.

P. Workers' Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

SECTION VIII. Claim Determinations

A. Claims.
A claim is a request that benefits or services be provided or paid according to the terms of this Contract. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider, either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us.

B. Notice of Claim.
Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling 888-857-0314 or visiting Our website at deltadentalins.com. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Contract. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Contract or visiting Our website at deltadentalins.com.

C. Timeframe for Filing Claims.
Claims for services must be submitted to Us for payment within 12 months after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 12 month period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.
We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by New York Public Health Law Section 238-a(1).

E. Claim Determinations.
Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our Claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Contract.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Contract.

F. Pre-service Claim Determinations.
1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

   If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You

(or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Pre-service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-service Claim Determinations.
A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period if We deny the claim in whole or in part.

H. Payment of Claims.
Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 day of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 15 days of Our determination that payment is due but no later than 30 days (for claims submitted through internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION IX. Grievance Procedures

A. Grievances.
Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.
You can contact Us in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or

Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

You may ask that We send You electronic notification of a Grievance or Grievance Appeal determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call 888-857-0314 or visit Our website at deltadentalins.com. You can opt out of electronic notifications at any time.

C. Grievance Determination.
Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 30 calendar days of receipt of Your Grievance.

D. Grievance Appeals.
If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided. One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.

Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
All Other Grievances: (That are not in relation To a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination.

E. Assistance.
If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If You need assistance filing a Grievance, You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400; or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION X. Utilization Review

A. Utilization Review.
We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call 888-857-0314. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for

determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call 888-857-0314 or visit Our website at deltadentalins.com.

You may ask that We send You electronic notification of a Utilization Review determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call 888-857-0314 or visit Our website at deltadentalins.com. You can opt out of electronic notifications at any time.

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45-day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of 15 calendar days of receipt of part of the requested information or 15 calendar days of the end of the 45-day time period.
2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or of one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour time period.

D. Retrospective Reviews.
If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services.
We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Reconsideration.
If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, Your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

G. Utilization Review Internal Appeals.
You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone or in writing. You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This

acknowledgment will if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is (1) a Physician or (2) a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

H. Standard Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within the earlier of 30 calendar days of receipt of the information necessary to conduct the Appeal or 60 days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

   If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal appeal or an external appeal.

   Our failure to render a determination of Your Appeal within 30 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

I. Full and Fair Review of an Appeal.

We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connections with Your Appeal.

The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

J. Appeal Assistance.

If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017

Or call toll free: 1-888-614-5400, or email cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XI. External Appeal

A. Your Right to an External Appeal.

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Contract; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
    - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
    - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
    - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your Right to Appeal A Determination that A Service Is Not Medically Necessary.

If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

C. Your Right to Appeal A Determination that A Service is Experimental or Investigational.

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; **or**
2. There does not exist a more beneficial standard service or procedure covered by Us; **or**
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or

2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

D. The External Appeal Process.
You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, We will provide coverage subject to the other terms and conditions of this Contract. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Contract for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

E. Your Responsibilities.
It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION XII. Termination of Coverage

This Contract may be terminated as follows:

A. Automatic Termination of this Contract.
This Contract shall automatically terminate upon the death of the Subscriber, unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, this Contract will terminate as of the last day of the month for which the Premium has been paid.

B. Automatic Termination of Your Coverage.
Coverage under this Contract shall automatically terminate:

1. For Spouses in cases of divorce, the date of the divorce.

2. For Children, the end of the month in which the Child turns 26 years of age.

3. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.

C. Termination by You.
The Subscriber may terminate this Contract at any time by giving the NYSOH at least 14 days' prior written notice.

D. Termination by Us.
We may terminate this Contract with 30 days' written notice as follows:

1. For Non-payment of Premiums.
   Premiums are to be paid by the Subscriber to Us on each Premium due date. While each Premium is due by the due date, there is a grace period for each Premium payment. If the Premium payment is not received by the end of the grace period, coverage will terminate as follows:

- If the Subscriber does not receive advanced payments of the Premium Tax Credit for coverage in the NYSOH and fails to pay the required Premium within a 30-day grace period, this Contract will terminate retroactively back to the last day Premiums were paid. The Subscriber will be responsible for paying any claims submitted during the grace period if this Contract terminates.
- If the Subscriber receives advanced payments of the Premium Tax Credit and has paid at least one (1) full month's Premium, this Contract will terminate one (1) month after the last day Premiums were paid. That is, retroactive termination will not exceed 61 days. We may pend claims incurred during the 61-day grace period. The Subscriber will be responsible for paying any claims incurred during the 61-day grace period if this Contract coverage terminates.

2. Fraud or Misrepresentation of Material Fact.
   If the Subscriber has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, this Contract will terminate immediately upon a written notice to the Subscriber from the NYSOH. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

3. If the Subscriber no longer lives or resides in Our Service Area.

4. The date the Contract is terminated because We stop offering the class of contracts to which this Contract belongs, without regard to claims experience or health related status of this Contract. We will provide the Subscriber with at least 90 days' prior written notice.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

SECTION XIII. Extension of Benefits

Upon termination of insurance, whether due to termination of eligibility, or termination of the Contract, an extension of benefits shall be provided for a period of no less than 30 days for completion of a dental procedure that was started before Your coverage ended.

SECTION XIV. Temporary Suspension Rights for Armed Forces' Members

If You, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. You serve no more than five (5) years of active duty.

You must make written request to Us to have Your coverage suspended during a period of active duty. Your unearned premiums will be refunded during the period of such suspension.

Upon completion of active duty, Your coverage may be resumed as long as You:

1. Make written application to Us; and
2. Remit the premium within 60 days of the termination of active duty.

The right of resumption extends to coverage for Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION XV. General Provisions

1. Agreements between Us and Participating Providers.

Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Contract does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any dental benefits program.

2. Assignment.

You cannot assign any benefits under this Contract to any person, corporation, or other organization and any such assignment will be void and unenforceable. You cannot assign any monies due under this Contract to any person, corporation or other organization Assignment means the transfer to another person, corporation or organization of Your right to the services provided under this Contract or Your right to collect money from Us for those services.

3. Changes in This Contract.

We may unilaterally change this Contract upon renewal, if We give You 45 days' prior written notice.

4. Choice of Law.

This Contract shall be governed by the laws of the State of New York.

5. Clerical Error.

Clerical error, whether by You or Us, with respect to this Contract, or any other documentation issued by Us in connection with this Contract, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. Conformity with Law.

Any term of this Contract which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.

Some of the benefits in this Contract may be limited to a specific number of visits, a benefit maximum, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

8. Entire Agreement.

This Contract, including any endorsements, riders and the attached applications, if any, constitutes the entire Contract.

9. Fraud and Abusive Billing.
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

10. Furnishing Information and Audit.
All persons covered under this Contract will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Contract. You must provide Us with certain information over the telephone for reasons such as the following: to determine the level of care You need; so that We may certify care authorized by Your Provider; or make decisions regarding the medical necessity of Your care.

11. Identification Cards.
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Contract. To be entitled to such services or benefits, Your Premiums must be paid in full at the time that the services are sought to be received.

12. Incontestability.
No statement made by the Subscriber in an application for coverage under this Contract shall avoid the Contract or be used in any legal proceeding unless the application or an exact copy is attached to this Contract.

13. Input in Developing Our Policies.
Subscribers may participate in the development of Our policies by writing to Delta Dental of New York, Inc., Attn: New York Enrollee Input, P.O. Box 2105, Mechanicsburg, PA 17055-2105.

14. Material Accessibility.
We will give You ID cards, Contracts, riders, and other necessary materials.

15. More Information about Your Dental Plan.
You can request additional information about Your coverage under this Contract. Upon Your request, We will provide the following information.:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- A copy of Our clinical review criteria (e.g. Medical Necessary criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines.
- Written application procedures and minimum qualification requirements for Providers.

16. Notice.

Any notice that We give You under this Contract will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: Delta Dental of New York, Inc., P.O. Box 2105, Mechanicsburg, PA 17055-2105.

17. Premium Payment.

The first month's Premium is due and payable when You apply for coverage. Coverage will begin on the effective date of the Contract as defined herein. Subsequent Premiums are due and payable on the first of each month thereafter. We will not accept Premium payments from third party entities except that We will accept premium payments from: a Ryan White HIV/AIDS Program; an Indian tribe, tribal organization, or urban Indian organization; or a local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

18. Premium Refund.

We will give any refund of Premiums, if due, to Subscriber.

19. Recovery of Overpayments.

On occasion a payment may be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

20. Renewal Date.

The renewal date for the Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date unless otherwise terminated by Us or You, as permitted by this Contract.

21. Reinstatement after Default.

If the Subscriber defaults in making any payment under this Contract, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Contract, but with respect to sickness and injury, only to Cover such sickness as may be first manifested more than 10 days after the date of such acceptance.

22. Right to Develop Guidelines and Administrative Rules.

We may develop or adopt standards that describe in more detail when We will or will not make payments under this Contract. Those standards will not be contrary to the descriptions in this Contract. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Contract.

We review and evaluate new technology according to technology evaluation criteria developed by Our medical directors and reviewed by a designated committee, which consists of health care professionals from various medical specialties. Conclusions of the committee are incorporated into Our medical policies to establish decision protocols for determining whether a service is Medically Necessary, experimental or investigational, or included as a Covered benefit.

23. Right to Offset.

If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

24. Severability.

The unenforceability or invalidity of any provision of this Contract shall not affect the validity and enforceability of the remainder of this Contract.

25. Significant Change in Circumstances.

If We are unable to arrange for Covered Services as provided under this Contract as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

26. Third Party Beneficiaries.

No third party beneficiaries are intended to be created by this Contract and nothing in the Contract shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Contract. No other party can enforce this Contract's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Contract, or to bring an action or pursuit for the breach of any terms of this Contract.

27. Time to Sue.

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Contract. You must start any lawsuit against Us under this Contract within three (3) years from the date the claim was required to be filed.

28. Translation Services.

Translation services are available free of charge under this Contract for non-English speaking Members. Please contact Us at 888-857-0314 to access these services.

29. Waiver.

The waiver by any party of any breach of any provision of this Contract will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

30. Who May Change this Contract.

This Contract may not be modified, amended, or changed, except in writing and signed by Our Chief Operating Officer ("COO") or a person designated by the COO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Contract in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the COO or person designated by the COO.

31. Who Receives Payment under this Contract.

Payments under this Contract for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.

32. Workers' Compensation Not Affected.

The coverage provided under this Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

33. Your Dental Records and Reports.

In order to provide Your coverage under this Contract, it may be necessary for Us to obtain Your dental records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Contract, except as prohibited by state or federal law, You automatically give Us or Our designee permission to obtain and use Your dental records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a dental professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a dental professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your dental records by Us.

We agree to maintain Your dental information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Contract, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

SECTION XVI

Delta Dental Individual & Family
Delta Dental PPO
Basic Plan for Families

SCHEDULE OF BENEFITS

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
PEDIATRIC DENTAL CARE ESSENTIAL HEALTH BENEFIT			
Deductible			
• One (1) Member under Age 19	$65 each Plan Year	$65 each Plan Year	The Deductible is a combined In-Network and Out-of-Network Deductible
• Two (2) or More Members under Age 19	$195 each Plan Year	$195 each Plan Year	
Out-of-Pocket Limit			
• One (1) Member under Age 19	$425 each Plan Year	Not Applicable	
• Two or More Members under Age 19	$850 each Plan Year	Not Applicable	
Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.			
SUMMARY OF PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFIT & CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care			
• Emergency Dental Care	50% Coinsurance after Deductible	50% Coinsurance after Deductible	

• Preventive Dental Care	0% Coinsurance after Deductible	0% Coinsurance after Deductible	Two (2) Cleanings per Plan Year
• Routine Dental Care	0%-50%* Coinsurance after Deductible *see "Pediatric Dental Care Essential Health Benefit" section for Coinsurance level	0%-50%* Coinsurance after Deductible *see "Pediatric Dental Care Essential Health Benefit" section for Coinsurance level	Two (2) Dental Exams per Plan Year Full mouth X-rays or panoramic X-rays at 36 month intervals and bitewing X-rays at six month intervals
• Endodontics	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Periodontics	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Prosthodontics	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Oral Surgery	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Orthodontics **Orthodontics require Preauthorization**	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
PEDIATRIC DENTAL CARE ESSENTIAL HEALTH BENEFIT	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• Dental examinations and consultations	0% Coinsurance after Deductible	0% Coinsurance after Deductible	Two (2) Dental Exams per Plan Year
• X-rays, full mouth x-rays or panoramic x-rays	0% Coinsurance after Deductible	0% Coinsurance after Deductible	Full mouth X-rays or panoramic X-rays at 36 month intervals and bitewing X-rays at six month intervals
• Visits; Simple extractions and other routine dental surgery not requiring hospitalization; In-office conscious sedation; Amalgam, composite restorations and stainless steel crowns; Other restorative materials	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Temporomandibular Joint (TMJ) Dysfunction	50% Coinsurance after Deductible	50% Coinsurance after Deductible	

ADULT DENTAL CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Deductible			
• Individual	$50 each Plan Year	$50 each Plan Year	
• Family	$150 each Plan Year	$150 each Plan Year	
Out-of-Pocket Limit			
• Individual	Not Applicable	Not Applicable	
• Family	Not Applicable	Not Applicable	
Annual Maximum	$1,000 per Enrollee per Plan Year	$1,000 per Enrollee per Plan Year	
Lifetime Maximum on Temporomandibular Joint (TMJ) Dysfunction	$300 per Enrollee per lifetime	$300 per Enrollee per lifetime	
ADULT DENTAL CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Adult Dental Care			
• Diagnostic & Preventive	0% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Basic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
• TMJ	50% Coinsurance after Deductible	50% Coinsurance after Deductible	

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Contract, You will be responsible for the full cost of the services.

HIPAA Notice of Privacy Practices

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

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

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

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

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

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

PERMITTED USES AND DISCLOSURES OF YOUR PHI

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

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

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

Permitted uses and disclosures without an authorization

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

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

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

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

Disclosures made with your authorization

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

YOUR RIGHTS REGARDING PHI

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

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

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

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

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

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

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

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

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.
You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes

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

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

You have the right to be notified following a breach of unsecured protected health information.
We will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

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

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

CONTACTS

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

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-866-530-9675 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

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

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

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

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

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'į' yídóołtahígíí nihee hóló. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaago ałdó' nich'į' ádoolnį́łgo bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojį' béésh holdíílnih 1-866-530-9675 (TTY: 711) (Navajo)

Non-Discrimination Disclosure

Discrimination is Against the Law

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

deltadentalins.com

ENROLLEE NOTICES

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

Federal Notices:

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

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

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

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

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

State Notices:

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

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

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

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

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

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330