DeltaCare® USA

Alpha Dental Programs, Inc. Individual & Family

DeltaCare® USA
Preferred Plan for Families

Combined Contract and Disclosure Form

Provided by:

Alpha Dental Programs, Inc.
560 Mission Street, Suite 1300
San Francisco, CA 94105

Administered by:

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

HealthCare.gov
800-318-2596

Have a complaint or need help?

If You have a problem with a claim or Your Premium, call Your insurance company or HMO first. If You can't work out the issue, the Texas Department of Insurance may be able to help.

Even if You file a complaint with the Texas Department of Insurance, You should also file a complaint or appeal through Your insurance company or HMO. If You don't, You may lose Your right to appeal.

Delta Dental Insurance Company

To get information or file a complaint with Your insurance company or HMO:

Call: Quality Management 888-857-0337
Toll Free: 888-857-0337
Online: deltadentalins.com
Mail: P.O. Box 1860
Alpharetta, GA 30023-1860

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Delta Dental Insurance Company

Para obtener información o parapresentar una queja ante su compañía de seguros o HMO:

Llame a: Quality Management 888-857-0337
Teléfono gratuito: 888-857-0337
En línea: deltadentalins.com
Direccion postal: P.O. Box 1860
Alpharetta, GA 30023-1860

El Departmento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

Your Rights with a Health Maintenance Organization (HMO) Plan
Notice from the Texas Department of Insurance

Your plan
Your HMO dental plan contracts with Dentists, facilities, and other providers to treat its Enrollees. Providers that contract with Your dental plan are called "contracted providers" (also known as "in-network providers"). Contracted providers make up a dental plan's network. Your dental plan will only pay for dental care You get from Dentists and facilities in its network.

However, there are some exceptions, including for emergencies and when You didn't pick the Dentist.

Your plan's network
Your dental plan must have enough Dentists and facilities within its network to provide every service the dental plan covers. You shouldn't have to travel too far or wait too long to get dental care. This is called "network adequacy." If You can't find the dental care You need, ask Your dental plan for help. You have the right to receive the dental care You need under Your in-network Benefits.

If You don't think the network is adequate, You can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

List of dentists
You can get a directory of providers that are in Your dental plan's network.

You can get the directory online at deltadentalins.com or by calling 888-857-0337.

If You used your dental plan's directory to pick an in-network Dentist and they turn out to be Out-of-Network, You might not have to pay the extra cost that Out-of-Network Dentists charge.

Bills for dental care
If You got dental care from a Dentist that was Out-of-Network when You were at an in-network facility, and You didn't pick the Dentist, You won't have to pay more than Your regular Copayment, coinsurance, and deductible. Protections also apply if You got emergency dental care at an Out-of-Network facility or lab work or imaging in connection with in-network dental care.

If You get a bill for more than You're expecting, contact Your dental plan. Learn more about how You're protected from surprise dental bills at tdi.texas.gov.

Contract/Disclosure Form ("Contract")

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

Your dental plan is underwritten by Alpha Dental Programs, Inc. ("Company") and administered by Delta Dental Insurance Company ("Delta Dental"). This Contract discloses the terms and conditions of the individual DeltaCare® USA dental plan available in Texas. This Contract is issued in exchange for payment of the first installment of Premium and on the basis of the statements made on Your application through the Exchange. It takes effect on the Effective Date shown in the Individual Contract Information attachment included with this Contract. This Contract will remain in force unless otherwise terminated in accordance with its terms, until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where You live.

The Contract and Schedules constitute the entire Contract. For consideration of the Premium, Company agrees to provide the Benefits described in the Contract. Administrative functions described throughout this booklet may be performed by Delta Dental, as designated by Company.

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

TEN (10)-DAY RIGHT TO EXAMINE AND RETURN THIS CONTRACT

Please read this Contract. If this Contract was solicited by deceptive advertising or negotiated by deceptive, misleading, or untrue statements or if You are not satisfied, You may return this Contract within 10 days after You received it. Mail or deliver it to Us. Any Premium paid will be refunded. This Contract will then be void from its start. The subscriber is responsible for the costs of any services rendered during the 10 day period if the Contract is returned.

This Contract is signed for Alpha Dental Programs, Inc., as of its Effective Date by:



Michael G. Hankinson, Esq., President

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INTRODUCTION

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

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

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

Using This Contract

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

Contact Us

If You have any questions about Your coverage that are not answered here, please visit Our website at deltadentalins.com or call Our Customer Service Center at 888-857-0337.

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

DeltaCare USA Customer Service
P.O. Box 1803
Alpharetta, GA 30023-1803

Identification Number

Please provide the Enrollee's identification ("ID") number to Your Dentist whenever You receive dental services. ID cards are not required. If You wish to have an ID card, You may obtain one by visiting Our website at deltadentalins.com.

DEFINITIONS

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

Administrator: Delta Dental Insurance Company ("Delta Dental") or other entity designated by Us and operating as an Administrator in the state of Texas. Certain functions described in this Contract may be performed by the Administrator, as designated by Us.

Adult Benefits: Dental services under this Contract for people age 19 years and older.

Authorization: The process by which We determine if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits: Covered dental services provided under the terms of this Contract.

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

Contract: This agreement between Us and the Primary Enrollee including any application supplied by the Exchange and any Attachments. This Contract constitutes the entire agreement between the parties.

Contract Dentist: A Dentist who provides services in general dentistry and who has agreed to provide Benefits under the plan. Contract Dentists may provide services either personally, or through

associated Dentists, or other technicians or hygienists who may lawfully perform the services. Referrals for Specialized Services must be obtained from Your Contract Dentist.

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

Contract Specialty Care Dentist: A Dentist who provides Specialized Services and who has agreed to provide Benefits to Enrollees under the plan. Services obtained from a Contract Specialty Care Dentist must be referred by Your Contract Dentist.

Contract Year: The 12-month period starting on January 1st and each subsequent 12-month period thereafter. Contract Year can be less than 12 months if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change or other exceptional circumstance as determined by the Exchange.

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

Copayment: The amounts You are responsible to pay the treating Dentist, as set forth in Schedule A. Copayments must be paid at the time treatment is received.

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

Effective Date: The original date the plan starts.

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

Eligible Pediatric Individual: A person who is considered to be a Qualified Individual by the Exchange. Eligible Pediatric Individuals are eligible for Pediatric Benefits as described in this Contract.

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

Emergency Dental Services: Procedures provided in a Dentist's facility, emergency dental clinic or other comparable facility to evaluate and stabilize dental conditions of a recent onset and severity that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

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

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

Exchange: The Texas Health Benefit Exchange.

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

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

Out-of-Network: A Dentist who has not signed an agreement with Us to provide Benefits under the terms of this Contract.

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

Premium: The amount payable as provided in the Individual Contract Information attachment included with this Contract.

Procedure Code: The Current Dental Terminology® (CDT®) five-digit alphanumeric code assigned to a Single Procedure by the American Dental Association®.

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

Qualifying Status Change:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, the filing of a suit in which the responsible party seeks to adopt a child, addition of a step or foster child or death of a child);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee moves);
- court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by the Exchange.

Service Area: A geographic area where We are approved to provide dental coverage. Our Service Area map consists of the counties listed below. A copy of our Service Area map is attached to this EOC.

Anderson	Coke	Garza	Karnes	Montague	Starr
Andrews	Coleman	Gillespie	Kaufman	Montgomery	Stephens
Angelina	Collin	Glasscock	Kendall	Moore	Sterling
Aransas	Colorado	Goliad	Kenedy	Morris	Stonewall
Archer	Comal	Gonzales	Kent	Nacogdoches	Sutton
Armstrong	Comanche	Gray	Kerr	Navarro	Swisher
Atascosa	Concho	Grayson	Kimble	Newton	Tarrant
Austin	Cooke	Gregg	King	Nolan	Taylor
Bailey	Coryell	Grimes	Kinney	Nueces	Terry
Bandera	Cottle	Guadalupe	Kleberg	Oldham	Throckmorton
Bastrop	Crane	Hale	Knox	Orange	Titus
Baylor	Crockett	Hamilton	La Salle	Palo Pinto	Tom Green
Bee	Crosby	Hardeman	Lamar	Panola	Travis
Bell	Dallas	Hardin	Lamb	Parker	Trinity
Bexar	Dawson	Harris	Lampasas	Parmer	Tyler
Blanco	DeWitt	Harrison	Lavaca	Pecos	Upshur
Borden	Deaf Smith	Hartley	Lee	Polk	Upton
Bosque	Delta	Haskell	Leon	Potter	Uvalde
Bowie	Denton	Hays	Liberty	Presidio	Van Zandt
Brazoria	Dickens	Henderson	Limestone	Rains	Victoria
Brazos	Dimmit	Hidalgo	Live Oak	Randall	Walker

Brewster	Donley	Hill	Llano	Reagan	Waller
Briscoe	Duval	Hockley	Loving	Real	Ward
Brooks	Eastland	Hood	Lubbock	Red River	Washington
Brown	Ector	Hopkins	Lynn	Refugio	Webb
Burleson	El Paso	Houston	Madison	Robertson	Wharton
Burnet	Ellis	Howard	Marion	Rockwall	Wichita
Caldwell	Erath	Hudspeth	Martin	Runnels	Wilbarger
Calhoun	Falls	Hunt	Mason	Rusk	Willacy
Callahan	Fannin	Hutchinson	Matagorda	Sabine	Williamson
Cameron	Fayette	Irion	Maverick	San Augustine	Wilson
Camp	Fisher	Jack	McCulloch	San Jacinto	Winkler
Carson	Floyd	Jackson	McLennan	San Patricio	Wise
Cass	Foard	Jasper	McMullen	San Saba	Wood
Castro	Fort Bend	Jeff Davis	Medina	Schleicher	Yoakum
Chambers	Franklin	Jefferson	Menard	Scurry	Young
Cherokee	Freestone	Jim Hogg	Midland	Shackelford	Zapata
Childress	Frio	Jim Wells	Milam	Shelby	Zavala
Clay	Gaines	Johnson	Mills	Smith	
Cochran	Galveston	Jones	Mitchell	Somervell	

The following counties are not part of the Alpha Dental Programs, Inc. Service Area:

Collingsworth, Culberson, Dallam, Edwards, Hall, Hansford, Hemphill, Lipscomb, Motley, Ochiltree, Reeves, Roberts,Sherman, Terrell, Val Verde, Wheeler.

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

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

Specialized Services: Services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics or pediatric dentistry.

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

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

Teledentistry: dental services delivered by a Dentist acting within the scope of the Dentist's license, or by a health professional acting under the Dentist's delegation and supervision and within the scope of the health professional's license or certification. Teledentistry includes services delivered through telehealth or telecommunications that may include the use of real-time encounter; live video (synchronous) or information stored and forwarded for subsequent review (asynchronous).

ELIGIBILITY AND ENROLLMENT

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

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

Eligibility Requirements for Pediatric Benefits

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

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

Pediatric Enrollees eligible for Pediatric Benefits are:

- a Primary Enrollee or an emancipated minor to age 19; and/or
- a Primary Enrollee's Spouse under age 19 and dependent children from birth to age 19. Dependent children include natural children, stepchildren, grandchildren, foster children, adopted children, children placed for adoption and children of Spouse. The grandchild must be financially dependent for federal income purposes on the Enrollee at the time the application for the grandchild is made.

Newborn infants are eligible from the moment of birth. Adopted children are eligible from the time the responsible party is a party in a suit in which the adoption of a child by the responsible party is sought. A newborn or adopted child will automatically be covered 31 days after birth or adoption. For coverage to continue after the 31-day period, verbal or written notice of birth or notice regarding the suit to adopt and any additional Premiums, if any, must be received within the 31-day period. Coverage for a grandchild may not be terminated solely because the grandchild's parent is no longer dependent upon the responsible party for federal income tax purposes.

You must live, reside or work in Our Service Area. The permanent legal residence of any enrolled dependent must be the same as yours, or You must live, reside or work in the Service Area and the residence of any enrolled dependent must be:

- In Our Service Area with the person having temporary or permanent conservatorship or guardianship of such dependents, where You have legal responsibility for the health care of such dependents; or
- In Our Service Area under other circumstances where You are legally responsible for the health care of such dependents; or
- In Our Service Area with Your Spouse; or
- Anywhere in the United States for a child whose coverage under the plan is required by a medical or dental support order.

Children Under Medical and Dental Support Orders

Coverage is also extended to any child who is recognized under a medical or dental support order. The non-responsible party or the child may request coverage under the responsible party's coverage. Coverage for the child is automatic for the first 31 days after receipt of a medical or dental support order or notice of a medical or dental support order. An additional Premium may be required for the initial 31-day period of coverage. Additionally, in order for coverage to continue beyond the initial 31-day period, an additional Premium may be required. Documentation of the above must be furnished upon Our request.

Children receiving coverage outside Our Service Area will be comparable to dental coverage provided to children in Our Service Area. Comparable dental coverage may include coverage in which the Program uses different procedures for service delivery and health care provider reimbursement, but may not include coverage that is:

- Limited to Emergency Dental Services only; or
- Charged a higher Premium.

Eligibility Requirements for Adult Benefits

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

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

Adult Enrollees eligible for Adult Benefits are:

- a Primary Enrollee age 19 years of age or older; and/or
- a Primary Enrollee's Spouse age 19 and older and dependent children from age 19 to age 26. Dependent children include natural children, stepchildren, grandchildren, foster children, adopted children, children placed for adoption and children of Spouse. The grandchild must be financially dependent for federal income purposes on the Enrollee at the time the application for the grandchild is made.

You must live, reside or work in Our Service Area. The permanent legal residence of any enrolled dependent must be the same as yours, or You must live, reside or work in the Service Area and the residence of any enrolled dependent must be:

- In Our Service Area with the person having temporary or permanent conservatorship or guardianship of such dependents, where You have legal responsibility for the health care of such dependents; or
- In Our Service Area under other circumstances where You are legally responsible for the health care of such dependents; or
- In Our Service Area with Your Spouse; or
- Anywhere in the United States for a child whose coverage under the plan is required by a medical or dental support order.

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

- they are incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
- they are chiefly dependent on the Primary Enrollee or Spouse for support; and
- proof of disability is provided within 31 days of request. Such requests will not be made more than once a year following a two year period after dependents reach the limiting age. Eligibility will continue as long as the dependent relies on the Primary Enrollee or Spouse for support because of a mental or physical disability that began before reaching the limiting age.

Enrollment

Eligible Primaries must be enrolled within 31 days after the date of becoming eligible or during an Open Enrollment Period. Coverage may not be changed at any time other than during an Open Enrollment Period unless there is a Qualifying Status Change.

Renewal

This Contract remains in effect for the Contract Year, provided it is not terminated by Us or by the Primary Enrollee. The Primary Enrollee will receive renewal information from the Exchange prior to any applicable Open Enrollment Period. The Primary Enrollee may change plan selections with the

Exchange during the Open Enrollment Period. Provided We continue to make this Contract available through the Exchange at the renewal period:

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

We will provide 60 days' advance written notice of any change in Premium at renewal.

Termination of Coverage

The Primary Enrollee has the right to terminate coverage under this Contract by contacting the Marketplace Call Center. The effective date of termination will be the date reported by the Exchange. If coverage is terminated because the Enrollee is covered by Medicaid, the last day of coverage with Us is the day before the new coverage is effective.

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

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

- Enrollee no longer eligible through the Exchange or under the terms of this Contract;
- non-payment of Premiums, subject to the "*Grace Period on Late Payments*" provision;
- upon 15 days' written notice if the Enrollee commits fraud or material misrepresentation made by or with the knowledge of the Primary Enrollee or the Enrollee applying for this coverage or filing a claim for Benefits;
- the Primary Enrollee changing to a new contract through the Exchange;
- the Enrollee no longer lives, resides or works in Our Service Area. Coverage may be cancelled after 30 days' written notice. However, coverage for a child who is the subject of a medical or dental support order cannot be cancelled solely because the child does not live, reside or work in Our Service Area; or
- upon 90 days' written notice in case of discontinuance and We cease to renew all Contracts issued on this form to residents of the state where You live.

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

If Your coverage is terminated, We will send a written notice to You informing You of the reasons(s) why coverage is terminated and the date that Your coverage will end. For treatment in progress, We will continue to provide Benefits less any applicable Copayment.

If an Enrollee loses coverage due to a change in marital status, the Enrollee will be issued a Contract that most nearly approximates the coverage of the Contract which was in effect prior to the change in marital status. The new Contract will be issued without evidence of insurability and will have the same effective date as the Contract under which coverage was prior to the change in marital status. The Contract will have the same expiration date as the Contract under which coverage was issued prior to the change in marital status except that We and the Enrollee may agree on a later expiration date.

Reinstatement

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

If any renewal Premium is not paid within the time granted the Primary Enrollee for payment, a subsequent acceptance of Premium by Us without also requiring an application for reinstatement will reinstate the Contract. However, if We require an application for reinstatement and issues a conditional receipt for the Premium tendered, the Contract will be reinstated upon approval of such application by Us, or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified the applicant in writing of Our disapproval of such application.

The reinstated Contract will cover only loss due to dental that begins more than ten days after such date. In all other respects the Enrollee and We will have the same rights thereunder as they had under the Contract immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement will be applied to a period for which Premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

OVERVIEW OF DENTAL BENEFITS

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

What is the DeltaCare USA HMO Plan?

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

Benefits, Limitations and Exclusions

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

You may obtain treatment for Benefits even though You are unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by Your physician or Dentist providing the dental service.

Teledentistry: A covered Benefit appropriately provided through Teledentistry is covered on the same basis and to the same extent that the covered Benefit is provided through an in-person diagnosis, consultation, or treatment.

Copayments and Other Charges

You are required to pay any Copayments listed in the Schedules attached to this Contract. Copayments are paid directly to the Dentist who provides treatment.

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

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

Choice of Contract Dentist Facility

We provide Contract Dentists at convenient locations during the term of this Contract. Upon enrollment, We will assign You to a Contract Dentist facility.

You may request a change to Your assigned Contract Dentist facility by calling Our Customer Service Center at 888-857-0337. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. The change must be requested prior to the 15th of the month to become effective on the first day of the following month.

Inquiries regarding availability of appointments and accessibility of Dentists should be directed to Our Customer Service Center at 888-857-0337. If You live in Our Service Area and there is no Contract Dentist within 75 miles, You have the right to self-refer to an Out-of-Network Dentist to obtain Benefits. We will reimburse the Out-of-Network Dentist at the Contract Dentist reimbursement or in-network Benefit level. Copayments may apply. Please refer to Schedule A.

If Your Contract Dentist becomes unavailable, We may request You select another Contract Dentist or one will be assigned to You.

Changing Contract Dentist Facility

You may request to change Your assigned Contract Dentist at any time by contacting Our Customer Service Center. Requests to change Your Contract Dentist must be made prior to the 15th of the month for the change to become effective on the first day of the following month.

Any dental treatment in progress must be completed before You change to another Contract Dentist such as: 1) partial or full dentures for which final impressions have been taken; and 2) all work on any tooth upon which work has started (such as completion of root canals in progress, and delivery of crowns when teeth have been prepared).

Changes in Dentist Participation

If the Dentist You selected is no longer a Contract Dentist under the plan, You may need to select a different Contract Dentist or We will assign a Contract Dentist. If this occurs, We will notify You and assist with selecting another Contract Dentist.

If You are receiving services that are not yet completed, that Contract Dentist will complete the procedure.

Coordination of Care and Referrals

Services which are Benefits must be provided by the Contract Dentist assigned to You. We have no obligation or liability with respect to services provided by Out-of-Network Dentists when Contract Dentists are available to provide such services, with the exception of Emergency Dental Services or Specialized Services referred by a Contract Dentist and authorized by Us. All authorized Specialized Services claims will be paid less any applicable Copayments.

If there is no Contract Dentist within 75 miles, You may self-refer to a non-contracted Dentist for Benefits. If there is no Contract Orthodontist or Contract Specialty Care Dentist within 75 miles, the Contract Dentist may refer You to a non-contracted orthodontist or non-contracted specialist or You may self-refer to a non-contracted Dentist for Specialized Services.

If Your Contract Dentist has questions about Your eligibility or Benefits, refer the Contract Dentist to Us.

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

Completion of Services

If You are a new Enrollee, You may request the completion of covered services begun prior to Your coverage under this plan. We will not provide coverage for incomplete services that are not otherwise Benefits under the terms and conditions of this Contract. To request completion of treatment in progress, call Our Customer Service Center or send Us a written request.

Whenever possible, You should complete treatment in progress with the Dentist who initiated the service. If the Dentist is an Out-of-Network Dentist, that Dentist must agree to the same terms and conditions that apply to Contract Dentists in order for Us to provide Benefits. Copayments will apply.

Should You not be able to complete treatment with the Dentist who initiated the service, We will make reasonable and appropriate arrangements for completion of the treatment by a Contract Dentist.

YOU MUST GO TO YOUR ASSIGNED CONTRACT DENTIST TO OBTAIN BENEFITS, EXCEPT FOR SERVICES PROVIDED BY A CONTRACT SPECIALTY CARE DENTIST, OR FOR EMERGENCY DENTAL SERVICES. IF YOU LIVE IN OUR SERVICE AREA AND THERE ARE NO CONTRACT DENTISTS, CONTRACT ORTHODONTISTS OR CONTRACT SPECIALTY CARE DENTISTS WITHIN 75 MILES OF YOUR HOME ADDRESS, YOU MAY SELF-REFER TO AN OUT-OF-NETWORK DENTIST FOR COVERED SERVICES, AND YOU WILL BE HELD HARMLESS FROM ANY ADDITIONAL FEES IN EXCESS OF YOUR COPAYMENT. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PLAN.

Medically Necessary Services

For favorable preauthorization determinations for medically necessary and appropriate services to an Enrollee, We will issue such preauthorization within three (3) calendar days. If We receive a request to renew an existing preauthorization 60 days prior to its expiration, We will review the request and issue a determination indicating whether the service is preauthorized. If the Dentist meets exemption criteria, preauthorization will not be required.

If medically necessary services are not available within Our Service Area, at the Contract Dentist's request and receipt of reasonably requested documentation, and within the time appropriate to the circumstances, but in no event no later than five (5) business days, We will allow a referral to an Out-of-Network Dentist. We will fully reimburse the Out-of-Network Dentist at the usual and customary or agreed upon rate. Copayments may apply. Please refer to Schedule A.

This requirement does not apply if You live in Our Service Area and there are no Contract Dentists, Contract Orthodontists or Contract Specialty Care Dentists within 75 miles of Your home address. You may self-refer to an Out-of-Network Dentist in this instance. Prior Authorization is not necessary. We will reimburse the Out-of-Network Dentist at the Contract Dentist, Contract Orthodontist or Contract Specialty Care Dentist reimbursement or in-network Benefit level. Copayments may apply. Please refer to Schedule A.

If You receive a bill from the Out-of-Network Dentist, You may contact Our Customer Service Center at 888-857-0337 for assistance.

Emergency Dental Services

Your assigned Contract Dentist maintains a 24-hour Emergency Dental Services system seven (7) days a week. If Emergency Dental Services are needed, You should contact the Contract Dentist whenever possible. If You are unable to reach Your Contract Dentist for Emergency Dental Services, You may call Our Customer Service Center at 888-857-0337 for assistance in obtaining urgent care. You may seek immediate treatment from another Dentist and We will reimburse You for the cost of

Emergency Dental Services which exceeds Your Copayment. If You receive emergency care services and a bill for Emergency Dental Services, please contact Our Customer Service Center at 888-857-0337 for assistance.

Emergency Dental Services are covered in accordance with the listed procedures as described in code D9110 "Palliative (emergency) treatment of dental pain." Further treatment must be obtained from the assigned Contract Dentist. (Refer to Schedule A and Schedule B.)

Specialized Services

Specialized Services for oral surgery, endodontics, orthodontics, periodontics or pediatric dentistry must be referred by the assigned Contract Dentist and authorized by Us within five (5) business days. All authorized Specialized Services will be paid by Us less any applicable Copayments. We will authorize the referral of an Out-of-Network Dentist within five (5) business days after receipt of reasonably requested documentation.

If You need Specialized Services and there is no Contract Orthodontist or Contract Specialty Care Dentist to provide these services within 75 miles of Your home address, the assigned Contract Dentist is NOT required to receive Authorization from Us to refer You to an Out-of-Network Dentist to provide the Specialized Services. You may self-refer to an Out-of-Network Dentist without receiving a referral from Your Contract Dentist. We will reimburse the Out-of-Network Dentist at the Contract Orthodontist or Contract Specialty Care Dentist reimbursement or in-network Benefit level. Prior Authorization is not necessary. Copayments may apply. Please refer to Schedule A.

If You need services from a Contract Orthodontist, please refer to Orthodontics in the Schedules attached to this Contract to determine Benefits.

Claims for Reimbursement

Claims for covered Emergency Dental Services, authorized Specialized Services or Out-of-Network Services, or if You self-refer to an Out-of-Network Dentist as outlined above, must be submitted to Us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if You can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one (1) year of the treatment date. The address for claims submission is Claims Department, P.O. Box 1810, Alpharetta, GA 30023-1810.

Payment of claims will be as follows:

1) Within 15 days after receipt of the claim, We will:
    a) Acknowledge receipt of the claim:
    b) Initiate an investigation of the claim; and
    c) Request any necessary information necessary to adjudicate the claim.
2) No later than 15 days after request of any requested information, We will notify you:
    a) Of the acceptance or rejection of the claim and the reason, if rejected; or
    b) That additional time is necessary to adjudicate the claim and the reason for the delay.
3) No later than the 45 days after You have been notified of the need for additional time needed to make a decision, We will accept or reject the claim. Accepted claims will be paid no later than the fifth (5^{th}) business day following notice of acceptance.
4) If payment is subject to performance of an act by You, the claim will be paid no later than the fifth (5^{th}) business day after the date the act is performed.

In the event We fail to pay a Contract Dentist, You will not be liable to that Dentist for any sums owed by Us.

Except for *Emergency Dental Services* and self-referrals outlined above, if You have not received Authorization for treatment from an Out-of-Network Dentist, and We fail to pay that Out-of-Network Dentist, You may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Dental Services* and *Specialized Services*.

Processing Policies

Our DeltaCare USA dental care guidelines explain the services covered under this Contract. Contract Dentists use professional judgment to determine which services are appropriate for Enrollees. Benefits performed by Contract Dentists are provided subject to any Copayments. If a Contract Dentist believes that You or any Enrollee should seek treatment from a Contract Orthodontist or Contract Specialty Care Dentist, the Contract Dentist contacts Us for a determination of whether the proposed treatment is a covered Benefit. We will also determine whether the proposed treatment requires treatment by a specialist. You may contact Our Customer Service Center at 888-857-0337 for information regarding the dental care guidelines for DeltaCare USA.

PREMIUM PAYMENT RESPONSIBILITIES

Your Premium is determined by the plan design chosen at the time of enrollment and any subsidy You receive, if applicable. Premiums are listed in the Individual Contract Information attachment included with this Contract. The Primary Enrollee is responsible for making Premium payments.

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

Alpha Dental Programs, Inc.
P.O. Box 660138
Dallas, TX 75266-0138

Rate Guarantee

Your Premium rate is guaranteed for each Contract Year based upon the new Enrollee rates in force at the time of Your enrollment. The rate guarantee can be less than 12 months if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change or due to other extraordinary circumstance as determined by the Exchange. We will provide 60 days' notice of any Premium rate changes.

Changing Payment Options

Payment options may be changed at any time. The effective date of any change is the date of the next scheduled payment based on Your new billing period. You can change Your payment option by visiting Our website at deltadentalins.com or by contacting Our Customer Service Center toll-free at 888-857-0337.

Grace Period on Late Payments

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

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

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

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

COMPLAINTS AND APPEALS OF ADVERSE DETERMINATIONS

Complaints

A "Complaint" means any dissatisfaction by an Enrollee, physician, Dentist or other person designated to act on behalf of the Enrollee orally or in writing about any aspect of Our operation, including but not limited to dissatisfaction with administration; procedures; denial, reduction or termination of services for reasons not related to medical necessity; disenrollment decisions or the quality of dental services performed by a Dentist. A Complaint does not include a misunderstanding or problem of misinformation which can be promptly resolved by supplying correct information to the Enrollee's satisfaction.

A "Complainant" is an Enrollee, physician, Dentist or other person designated to act on behalf of the Enrollee, who files a Complaint.

The Complainant may call the Customer Service Center at 888-857-0337, or the Complaint may be addressed in writing to:

Quality Management Department
P.O. Box 1860
Alpharetta, GA 30023-1860

Complaint Information

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

Should an Enrollee choose to have a physician, Dentist or other person act on the Enrollee's behalf during the Complaint process, the Enrollee must provide Us with express written permission designating that individual as their representative and include a signed release, compliant with HIPAA, authorizing the disclosure of confidential information such as their personal health information (PHI).

We will provide notification of any dental services are not covered Benefits, stating the specific Contract provision(s).

Within 5 business days after receipt of an oral or written Complaint, the quality management coordinator will send a letter acknowledging the date of receipt of the Complaint, and a description of Our Complaint procedures, estimated time frames for resolution of Complaints, and a request for any necessary information. If the Complaint was received orally, the acknowledgement will include a one-page Complaint form with instructions to return for resolution of the Complaint. Processing of a Complaint will generally not begin until We receive the information shown above, except as noted below for Complaints involving Emergency Dental Services.

The Complainant may call the Customer Service Center at 888-857-0337 at any time between 8:00 a.m. and 8:00 p.m., Central Time, to discuss the Complaint. Complaints requiring professional expertise will be referred to a licensed dental consultant or, if necessary, the dental director for response. Certain Complaints may also require a second opinion for a clinical evaluation of dental services provided. Second opinions will be provided by another Dentist's facility, unless otherwise authorized by Our dental consultant. We will pay for a second opinion that We have authorized.

We will resolve a Complaint involving Emergency Dental Services (involving emergency care denials, denials of care for life-threatening conditions, and denials of continued stays for hospitalization) within 24 hours after Our receipt. Complaints that do not involve Emergency Dental Services will be resolved within 30 calendar days after receipt. We will send to the Complainant a written report which

describes the Complaint, and Our resolution. The report will contain a statement of the specific clinical and/or contractual reasons for the resolution and will advise the Complainant of:

1) the specialization of any Dentist or other provider consulted,
2) a description of Our Complaint procedure, and
3) the time frames for Our appeal process and final decision.

Complaint Appeal

In the event a Complainant is not satisfied with Our resolution of a Complaint, the Complainant will have the right to appeal the decision before a complaint appeal panel. Within 5 business days after receipt of a request for an appeal, We will send a letter acknowledging the date of receipt of the request and include a statement of the Complainant's rights to:

1) appear before an appeal panel in person (or through a representative if a minor or disabled) in the area where the Enrollee received the care or at an agreed upon location, or
2) write to an appeal panel,
3) present alternative expert testimony,
4) present oral or written information, and
5) question those responsible for the prior resolution.

Our appeal panel is composed of Enrollee representatives, Dentist representatives and Delta Dental representatives in equal numbers. Dentists cannot review a case in which they rendered care or a case they reviewed during Our complaint or appeal process. The panel will include a Dentist of the appropriate specialty if the quality of specialty care is at issue. Our employees cannot serve as Enrollee members.

No later than 5 business days before the scheduled meeting of the appeal panel, unless the Complainant agrees otherwise, We will provide to the Complainant or the Complainant's designated representative:

1) any documentation to be presented to the panel by Us,
2) the specialization of any providers consulted during the investigation of the appeal, and
3) the name and affiliation of each Delta Dental representative on the panel.

We will send a written resolution of the appeal within 30 calendar days after receipt of an appeal. Investigation and resolution of appeals involving ongoing Emergency Dental Services will be concluded in accordance with the dental immediacy of the case, but no later than 24 hours after receipt of request for appeal. At the request of the Enrollee, We will provide, instead of an appeal panel, a Dentist who has not previously reviewed the case and who is of the same or similar specialty as ordinarily manages the procedure or treatment under appeal. The Dentist reviewing the appeal may interview the Enrollee or the Enrollee's designated representative and will make a decision on the appeal. Initial notice of decision of the appeal may be delivered orally, but will be followed by a written notice of the determination within 3 days.

Notice of Our final decision will include a statement of the specific clinical and/or Contract provision(s) on which the decision was based, and the toll-free telephone number and address of the Texas Department of Insurance.

Adverse Determination

An "Adverse Determination" is a determination by Us that the health care services provided or proposed to be provided to an Enrollee are not medically necessary or appropriate or are experimental or investigational.

Adverse Determination Information

In all instances of a utilization review Adverse Determination, written notification of the Adverse Determination will include:

1) the principal reasons for the Adverse Determination;
2) the clinical basis for the Adverse Determination;
3) a description or the source of the screening criteria that were utilized as guidelines in making the determination;
4) the professional specialty of the Dentist that made the Adverse Determination;
5) a description of the procedures for Our Complaint system;
6) a description of Our Appeal process;
7) a copy of the request for a review by an Independent Review Organization (IRO) form, available at *www.tdi.texas.gov/forms*;
8) notice of the independent review process with instructions that:
   A) request for a review by an IRO form must be completed by the Enrollee, an individual acting on behalf of the Enrollee, or the Enrollee's Dentist of record and be returned to Us that made the Adverse Determination to begin the independent review process; and
   B) the release of medical information to the IRO, which is included as part of the independent review request for a review by an IRO form, must be signed by the Enrollee or the Enrollee's legal guardian; and
9) a description of the Enrollee's right to an immediate review by an IRO and of the procedures to obtain that review for an Enrollee who has a life-threatening condition.

Adverse Determination Appeal

An “Appeal of Adverse Determination” or “Appeal” is a Complaint concerning dissatisfaction with an Adverse Determination, but does not include a Complaint regarding dissatisfaction with administration; procedures; denials, reduction or termination of services for reasons not related to medical necessity; disenrollment decisions, or the quality of dental service performed by a Dentist.

Unless the specific subscriber agreement allows additional time to respond, within one hundred eighty (180) days of receipt of an Adverse Determination, an Enrollee, Dentist, or other person designated to act on behalf of the Enrollee may call the Customer Service Center at 888-857-0337, or the Appeal may be addressed in writing to the address above.

An “Appealing Party” is an Enrollee, physician, Dentist or other person designated to act on behalf of an Enrollee, who may request reconsideration of an Adverse Determination.

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

Should an Enrollee choose to have a physician, Dentist or other person act on the Enrollee’s behalf during the Appeal process, the Enrollee must provide Us with express written permission designating that individual as their representative and include a signed release, compliant with HIPAA, authorizing the disclosure of confidential information such as their personal health information (PHI).

We will provide notification of any dental services are not covered Benefits, stating the specific Contract provision(s).

Within 5 business days after receipt of an oral or written Appeal, the quality management coordinator will send a letter acknowledging the date of receipt of the Appeal, and a description of Our Appeal procedures, estimated time frames for resolution of Appeals, and a request for any necessary information. If the Appeal was received orally, the acknowledgement will include a one-page Appeal

form with instructions to return for prompt resolution of the Appeal. Processing of an Appeal will generally not begin until We receive the information shown above, except as noted below for Appeals involving Emergency Dental Services.

The Appealing Party may call the Customer Service Center at 888-857-0337 at any time between 8:00 a.m. and 8:00 p.m., Central Time, to discuss the Appeal. Appeals requiring professional expertise will be referred to a licensed dental consultant or, if necessary, the dental director for response. Certain Appeals may also require a second opinion for a clinical evaluation of dental services provided. Second opinions will be provided by another Dentist's facility, unless otherwise authorized by Our dental consultant. We will pay for a second opinion that We have authorized.

We will resolve an Appeal involving Emergency Dental Services (involving emergency care denials, denials of care for life-threatening conditions, and denials of continued stays for hospitalization) within 24 hours after Our receipt. Appeals that do not involve Emergency Dental Services will be resolved within 30 calendar days after receipt. We will send to the Appealing Party a written report which describes the Appeal and Our resolution. The report will contain a statement of the specific clinical and/or contractual reasons for the resolution and will advise the Appealing Party of:

1) the specialization of any Dentist or other provider consulted,

2) a description of Our Appeal procedure, and

3) the time frames for Our Appeal process and final decision.

Notice of Our decision on an Appeal for Adverse Determination will include a statement of the specific clinical and/or Contract provision(s) on which the decision was based, and the toll-free telephone number and address of the Texas Department of Insurance.

Independent Review

In the event an Appealing Party is not satisfied with Our resolution of an Appeal, or if the Appeal relates to emergency care denials, denials of care for life-threatening conditions, and denials of continued stays for hospitalization, the Appealing Party has the right to file for review by an independent review organization or "IRO." The Enrollee, Dentist, or someone acting on behalf of the Enrollee may file for independent review by sending a REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION (IRO) form to Us at the address listed above. Upon receipt of an IRO request form, We will notify the Texas Department of Insurance within one (1) working day. Within three (3) working days, We will provide the IRO with copies of all relevant documents. We will comply with the IROs determination with respect to the medical necessity or appropriateness, or the experimental or investigational nature, of the health care items and services requested by the Enrollee.

Texas Department of Insurance

Any Enrollee, including an Enrollee who has attempted to resolve a Complaint through the Complaint process described above, may file a complaint with the Texas Department of Insurance at P.O. Box 12030, Austin, Texas 78711-2030. The Department's toll-free telephone number is 800-252-3439.

The commissioner will investigate a complaint against Us to determine Our compliance with the insurance laws within 60 days after the Department receives the complaint and all information necessary for the Department to determine compliance. The commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

1) additional information is needed;

2) an on-site review is necessary;

3) we, the Dentist, or the Complainant do not provide all documentation necessary to complete the investigation; or

4) other circumstances beyond the control of the Department.

We will not engage in any retaliatory action (including termination or refusal to renew a Contract) against a Contractholder, an Enrollee, or a Dentist (on behalf of an Enrollee) for filing a complaint or appealing a decision.

If You believe You need further review of Your claim, You may contact Your state insurance regulatory agency. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), You may contact the U.S. Department of Labor, Employee Benefits Security Administration

("EBSA"), for further review of the claim or if You have questions about the rights under ERISA. You may also bring a civil action under Section 502(a) of ERISA. The address of the U.S. Department of Labor is:

U.S. Department of Labor
Employee Benefits Security Administration (EBSA)
200 Constitution Avenue, N.W.
Washington, D.C. 20210

GENERAL PROVISIONS

Entire Contract; Changes

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

Severability

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

Incontestability

In the absence of fraud or intentional misrepresentation made by You in the enrollment application, all statements made in that application are representations and not warranties. The statements are considered to be truthful and are made to the best of Your knowledge and belief. A statement may not be used to void, cancel or non-renew Your coverage or reduce Benefits unless (i) it is in a written enrollment application signed by You, and (ii) a signed copy of the enrollment application is or has been furnished to You or Your personal representative.

Misstatements on Application; Effect

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

Legal Actions

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

Conformity with Applicable Laws

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

Third Party Administrator ("TPA")

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

Impossibility of Performance

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

Non-Discrimination 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, sexual orientation, pregnancy or related conditions and gender identity. We do not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

We

provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with Us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, braille, accessible electronic formats)

We provide free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages

If You need these reasonable modifications, appropriate auxiliary aids and services, for language assistance services, please call 888-857-0337 (TTY: 711).

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

DeltaCare USA
Appeals and Grievances Dept.
P.O. Box 1860
Alpharetta, GA 30023-1860
888-857-0337
deltadentalins.com
1557coordinator@delta.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

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

GLOSSARY

The following dental terms have the meanings indicated:

Abrasion - The abnormal wearing away of the tooth by chewing, incorrect brushing methods, grinding or similar causes.

Alveoloplasty - A surgical procedure to reshape the jaw bones to achieve normal bone contour in preparation for tooth replacement via denture, partials or bridges.

Amalgam - A metal alloy used in filling teeth.

Apicoectomy - The surgical removal of the root tip.

Appliance - A device used to provide function or therapeutic effect.

Attrition - The normal loss of tooth substance resulting from friction during chewing.

Banding - Application of preformed stainless steel rings that are fitted around the teeth and cemented in place.

Banding dentition - Treatment of a tooth which involves banding (for orthodontic purposes).

Cephalometric x-rays - X-rays used in studying the measurements of the head in relation to specific soft tissue and bony reference points.

Cleft palate - A birth defect resulting in an incomplete closure or formation of the palate.

Debridement - The removal of plaque and tartar, above and below the gumline, which makes the ability to evaluate the gum condition difficult.

Equilibration - Changing the occlusal forms of the teeth by selective grinding, with the interest of balancing occlusal stresses more evenly on the teeth.

Erosion - Chemical or mechanical destruction of tooth substance, the mechanism of which is incompletely known, that leads to the creation of a depression in the tooth surface at the gumline.

Exostosis - An excessive growth of bone.

Expansion appliance - An appliance used to widen a dental arch to increase the room available for permanent teeth and/or to correct the bite.

Frenum - The fibers that attach the cheek, lips or tongue to the tissue lining the mouth.

Frenectomy - Surgical removal or loosening of the frenum.

Functional appliance - An appliance used to achieve minor tooth movement, to strengthen the muscles of the oral cavity or to maintain space created by the loss or delayed eruption of the teeth.

Gingiva - The soft tissue which covers a tooth or the gum surrounding a tooth.

Gingivectomy - The surgical removal of the unsupported gingiva to the level where it is attached.

Gingivoplasty - Surgical contouring of the gingiva to facilitate maintenance of tissue health and integrity.

Headgear - An apparatus encircling the head or neck that provides attachment for an intraoral appliance in use of extraoral anchorage.

Implant - A device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement of a missing tooth.

Lingual - Pertaining to the tongue.

Macrognathia - A definite overgrowth of the mandible and maxilla.

Mandible - The lower jaw.

Mandibular - Pertaining to the lower jaw.

Maxilla - The upper jaw.

Maxillary - Pertaining to the upper jaw.

Micrognathia - An abnormal smallness of the jaws, especially the mandible.

Myofunctional therapy - Training to curb or eliminate abnormal muscle function of the oral cavity.

Occlusal - The chewing surfaces of the posterior teeth.

Occlusion - The contact between the upper and lower teeth when in a closed position.

Orthodontic appliance - Any appliance used to apply forces for tooth movement during orthodontic treatment.

Palate - The roof of the mouth.

Palatal - Pertaining to the roof of the mouth.

Palliative - Action that relieves pain but does not cure the cause of the pain.

Panoramic film - An x-ray that offers a full view of the entire length of the jaws in a single x-ray.

Pediatric or **Pedodontic** - Pertaining to children.

Periapical - The area surrounding or enclosing the root tip of a tooth.

Periodontitis - Gingival changes that occur due to infection and loss of attachment between the tooth and gums. Periodontitis is a long-term progressive disease.

Periradicular - Around the root.

Pontic - The term used for the artificial tooth on a bridge.

Prophylaxis - The removal of plaque, tartar and stains on the crown portion of the teeth, including polishing.

Pulp cap - The covering of an exposed dental nerve with material that protects it from foreign irritants.

Quadrant - One of the four equal sections into which the dental arches can be divided; begins at the middle of the arch and goes to the last tooth on either side.

Rebase - Process of refitting a denture by replacing the acrylic base material.

Resin - Broad term used to indicate an organic substance that is usually tooth colored. Composite resin used in filling teeth, most often in the front of the mouth.

Retainer - An appliance used to maintain the positions of the teeth and jaws gained by orthodontic procedures.

Retrograde filling - A method of sealing the root canal by preparing and filling it from the root tip.

Root planning - A procedure designed to remove bacteria, tartar and diseased root tissue from the root surfaces. Often referred to as “deep cleaning.”

Sealant - Application of a resin material to the biting surfaces of the permanent molars to seal the surface crevices to prevent the formation of decay.

Study model - A positive likeness of dental structures (teeth and adjoining tissues) for the purpose of study and treatment planning.

Supernumerary - Any tooth in excess of the 32 normal permanent teeth.

Temporomandibular joint - The joint formed by the connection of the lower jaw to the skull.

Tracing - As it relates to orthodontic treatment, a tracing is a line drawing of pertinent features of a cephalometric x-ray made on a piece of transparent paper placed over an x-ray. The tracing provides measurements of soft tissue and bony reference points that aid in predicting growth patterns and orthodontic diagnosis and treatment planning.

Trigeminal nerve - The main nerve that provides feeling to the muscles and tissues of the face, jaws and teeth.

Vertical dimension - The vertical height of the face with teeth in occlusion.

CONTRACT INFORMATION

Contractholder:

Effective Date:

Contract Year:

Contract ID Number:

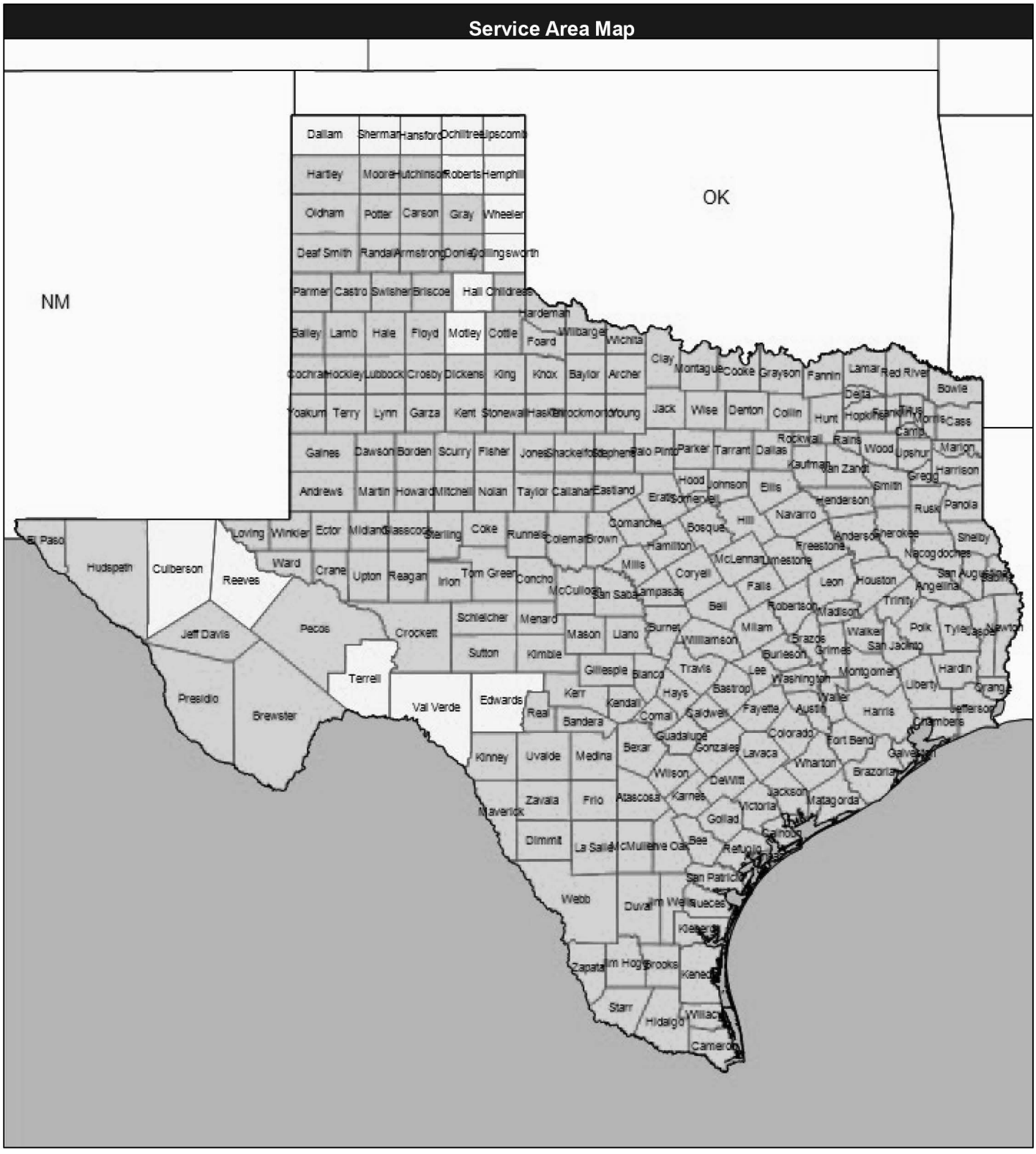
Premium Remittance:

Each Premium is to be paid to:
Alpha Dental Programs, Inc.
P.O. Box 660138
Dallas, TX 75266-0138

Monthly Premium:

Map

Service Area Map



© 2018 Quest Analytics, LLC.

Service Areas

- TDI Approved Counties

Approved April 15, 2019

105.92 miles

SCHEDULE A
Description of Benefits and Copayments
Alpha Dental Programs, Inc. Individual & Family
DeltaCare® USA
Preferred Plan for Families

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under this Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2025 Procedure Codes, descriptors or nomenclature which is under copyright by the American Dental Association® ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

Out-of-Pocket Maximum ("OOPM") for Pediatric Enrollees (Under Age 19)

Pediatric Enrollee:	**$450.00** each Calendar Year
Multiple Pediatric Enrollees:	**$900.00** each Calendar Year

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

If only one Pediatric Enrollee is covered under this Contract, the financial obligation for Benefits is not more than the Pediatric Enrollee OOPM. If two or more Pediatric Enrollees are covered under this Contract, the financial obligation for Benefits is not more than the Multiple Pediatric Enrollees OOPM. Once the amount paid by all Pediatric Enrollee(s) equals the OOPM shown above, no further payment will be required by any Pediatric Enrollee(s) for the remainder of the Calendar Year for Benefits.

We recommend that the Pediatric Enrollee or other party responsible for the Pediatric Enrollee keep a record of payment for Benefits. If You have any questions regarding Your OOPM, please contact the Customer Service Center at 888-857-0337.

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0100–D0999 I. DIAGNOSTIC					
D0999	Unspecified diagnostic procedure, by report	$5	$5	*Includes office visit, per visit (in addition to other services)*	*Includes office visit, per visit (in addition to other services)*
D0120	Periodic oral evaluation – established patient	No cost	No cost	*2 of (D0120, D0150, D0180) per Calendar Year*	*2 per Calendar Year*
D0140	Limited oral evaluation – problem focused	No cost	No cost	*2 of (D0140, D0170) per Contract Dentist per Calendar Year*	*2 per Calendar Year*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No cost	Not a Benefit		
D0150	Comprehensive oral evaluation – new or established patient	No cost	No cost	*2 of (D0120, D0150, D0180) per Calendar Year*	
D0160	Detailed and extensive oral evaluation – problem focused, by report	No cost	No cost		
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	No cost	No cost	*2 of (D0140, D0170) per Contract Dentist per Calendar Year*	
D0171	Re-evaluation – post-operative office visit	$10	$10		
D0180	Comprehensive periodontal evaluation – new or established patient	No cost	No cost	*2 of (D0120, D0150, D0180) per Calendar Year*	
D0190	Screening of a patient	No cost	No cost	*1 of (D0190, D0191) per 12 months*	*1 of (D0190, D0191) per 12 months*
D0191	Assessment of a patient	No cost	No cost	*1 of (D0190, D0191) per 12 months*	*1 of (D0190, D0191) per 12 months*
D0210	Intraoral – comprehensive series of radiographic images	$10	$5	*1 series per 60 months*	*1 series per 24 months*
D0220	Intraoral – periapical first radiographic image	No cost	No cost		
D0230	Intraoral – periapical each additional radiographic image	No cost	No cost		
D0240	Intraoral – occlusal radiographic image	No cost	No cost		
D0250	Extraoral – 2D projection radiographic image created using a stationary radiation source, and detector	Not a Benefit	No cost		
D0270	Bitewing – single radiographic image	No cost	No cost	*1 set per 6 months*	
D0272	Bitewings – two radiographic images	No cost	No cost	*1 set per 6 months*	
D0273	Bitewings – three radiographic images	No cost	No cost	*1 set per 6 months*	
D0274	Bitewings – four radiographic images	No cost	No cost	*1 set per 6 months*	*1 series per 6 months*
D0277	Vertical bitewings – 7 to 8 radiographic images	No cost	$5	*1 set per 6 months*	
D0330	Panoramic radiographic image	$10	$5	*1 image per 60 months*	*1 series per 24 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	$10	Not a Benefit		
D0350	2D oral/facial photographic image obtained intraorally or extraorally	$10	Not a Benefit		
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	No cost	Not a Benefit		
D0415	Collection of microorganisms for culture and sensitivity	Not a Benefit	No cost		
D0419	Assessment of salivary flow by measurement	No cost	No cost	*1 per 12 months*	*1 per 12 months*
D0425	Caries susceptibility tests	Not a Benefit	No cost		
D0460	Pulp vitality tests	No cost	No cost		
D0470	Diagnostic casts	No cost	No cost		
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Not a Benefit	No cost		*Available only when performed in conjunction with a covered biopsy*
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not a Benefit	No cost		*Available only when performed in conjunction with a covered biopsy*
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Not a Benefit	No cost		*Available only when performed in conjunction with a covered biopsy*
D0601	Caries risk assessment and documentation, with a finding of low risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0603	Caries risk assessment and documentation, with a finding of high risk	No cost	No cost	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*	*1 of (D0601, D0602, D0603) per 12 months when performed by the same Contract Dentist or office*
D0701	Panoramic radiographic image – image capture only	No cost	No cost		
D0702	2D cephalometric radiographic image – image capture only	No cost	Not a Benefit		
D0703	2D oral/facial photographic image obtained intraorally or extraorally – image capture only	No cost	Not a Benefit		
D0706	Intraoral – occlusal radiographic image – image capture only	No cost	No cost		
D0707	Intraoral – periapical radiographic image – image capture only	No cost	No cost		
D0708	Intraoral – bitewing radiographic image – image capture only	No cost	No cost		
D0709	Intraoral – comprehensive series of radiographic images – image capture only	No cost	No cost		
D1000-D1999 II. PREVENTIVE					
D1110	Prophylaxis – adult	$5	$5	*Cleaning; 2 of (D1110, D1120, D4346) per Calendar Year*	*Cleaning; 2 of (D1110, D4346) per 12 months*
D1110	Prophylaxis – adult	Not a Benefit	$45		*Up to 2 additional cleanings per 12 months*
D1120	Prophylaxis – child	$5	Not a Benefit	*Cleaning; 2 of (D1110, D1120, D4346) per Calendar Year*	
D1206	Topical application of fluoride varnish	$5	$5	*2 of (D1206, D1208) per Calendar Year*	*2 of (D1206, D1208) per 12 months*
D1208	Topical application of fluoride – excluding varnish	$5	$5	*2 of (D1206, D1208) per Calendar Year*	*2 of (D1206, D1208) per 12 months*
D1310	Nutritional counseling for control of dental disease	Not a Benefit	No cost		
D1320	Tobacco counseling for the control and prevention of oral disease	Not a Benefit	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D1330	Oral hygiene instructions	Not a Benefit	No cost		
D1351	Sealant – per tooth	$15	Not a Benefit	*Permanent molars without restorations or decay; 1 per 36 months*	
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	$5	Not a Benefit	*Permanent molars without restorations or decay; 1 per 36 months*	
D1354	Application of caries arresting medicament – per tooth	$5	$5	*1 per 6 months*	*2 per 12 months*
D1510	Space maintainer – fixed, unilateral – per quadrant	$70	Not a Benefit		
D1516	Space maintainer – fixed – bilateral, maxillary	$97	Not a Benefit		
D1517	Space maintainer – fixed – bilateral, mandibular	$97	Not a Benefit		
D1520	Space maintainer – removable, unilateral – per quadrant	$70	Not a Benefit		
D1526	Space maintainer – removable – bilateral, maxillary	$97	Not a Benefit		
D1527	Space maintainer – removable – bilateral, mandibular	$97	Not a Benefit		
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$15	Not a Benefit		
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$15	Not a Benefit		
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$15	Not a Benefit		
D1556	Removal of fixed unilateral space maintainer – per quadrant	No cost	Not a Benefit	*Included in case by Dentist/dental office who placed appliance; a separate charge applies for service provided by a Dentist other than the original treating Dentist/dental office*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D1557	Removal of fixed bilateral space maintainer – maxillary	No cost	Not a Benefit	*Included in case by Dentist/dental office who placed appliance; a separate charge applies for service provided by a Dentist other than the original treating Dentist/dental office*	
D1558	Removal of fixed bilateral space maintainer – mandibular	No cost	Not a Benefit	*Included in case by Dentist/dental office who placed appliance; a separate charge applies for service provided by a Dentist other than the original treating Dentist/dental office*	
D1575	Distal shoe space maintainer – fixed, unilateral – per quadrant	$70	Not a Benefit	*1 per quadrant per lifetime; Age 8 and under*	
D2000-D2999 III. RESTORATIVE					
– *Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.*					
– *The fee for removal of an indirect restoration is included in the fee for a subsequent restorative procedure.*					
– *Replacement of crowns, inlays and onlays requires the existing restoration to be 60+ months old.*					
D2140	Amalgam – one surface, primary or permanent	$25	$25		
D2150	Amalgam – two surfaces, primary or permanent	$30	$30		
D2160	Amalgam – three surfaces, primary or permanent	$50	$40		
D2161	Amalgam – four or more surfaces, primary or permanent	$55	$50		
D2330	Resin-based composite – one surface, anterior	$60	$40	*For primary or permanent teeth*	*For primary or permanent teeth*
D2331	Resin-based composite – two surfaces, anterior	$70	$50	*For primary or permanent teeth*	*For primary or permanent teeth*
D2332	Resin-based composite – three surfaces, anterior	$80	$60	*For primary or permanent teeth*	*For primary or permanent teeth*
D2335	Resin-based composite – four or more surfaces (anterior)	$105	$95	*For primary or permanent teeth*	*For primary or permanent teeth*
D2390	Resin-based composite crown, anterior	$155	$155		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2391	Resin-based composite – one surface, posterior	Not a Benefit	$65		
D2392	Resin-based composite – two surfaces, posterior	Not a Benefit	$80		
D2393	Resin-based composite – three surfaces, posterior	Not a Benefit	$90		
D2394	Resin-based composite – four or more surfaces, posterior	Not a Benefit	$115		
D2510	Inlay – metallic – one surface	$315	$315	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2520	Inlay – metallic – two surfaces	$315	$315	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2530	Inlay – metallic – three or more surfaces	$340	$340	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2542	Onlay – metallic – two surfaces	$335	$335	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2543	Onlay – metallic – three surfaces	$350	$350	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2544	Onlay – metallic – four or more surfaces	$350	$350	*Base metal is the Benefit; 1 per 60 months*	*Base metal is the Benefit; 1 per 60 months*
D2610	Inlay – porcelain/ceramic – one surface	Not a Benefit	$310		*1 per 60 months*
D2620	Inlay – porcelain/ceramic – two surfaces	Not a Benefit	$335		*1 per 60 months*
D2630	Inlay – porcelain/ceramic – three or more surfaces	Not a Benefit	$360		*1 per 60 months*
D2642	Onlay – porcelain/ceramic – two surfaces	Not a Benefit	$395		*1 per 60 months*
D2643	Onlay – porcelain/ceramic – three surfaces	Not a Benefit	$425		*1 per 60 months*
D2644	Onlay – porcelain/ceramic – four or more surfaces	Not a Benefit	$435		*1 per 60 months*
D2650	Inlay – resin-based composite – one surface	Not a Benefit	$185		*1 per 60 months*
D2651	Inlay – resin-based composite – two surfaces	Not a Benefit	$210		*1 per 60 months*
D2652	Inlay – resin-based composite – three or more surfaces	Not a Benefit	$245		*1 per 60 months*
D2662	Onlay – resin-based composite – two surfaces	Not a Benefit	$225		*1 per 60 months*
D2663	Onlay – resin-based composite – three surfaces	Not a Benefit	$245		*1 per 60 months*
D2664	Onlay – resin-based composite – four or more surfaces	Not a Benefit	$270		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2710	Crown – resin-based composite (indirect)	Not a Benefit	$145		*1 per 60 months*
D2712	Crown – 3/4 resin-based composite (indirect)	Not a Benefit	$145		*1 per 60 months*
D2720	Crown – resin with high noble metal	Not a Benefit	$485		*1 per 60 months*
D2721	Crown – resin with predominantly base metal	Not a Benefit	$410		*1 per 60 months*
D2722	Crown – resin with noble metal	Not a Benefit	$465		*1 per 60 months*
D2740	Crown – porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D2750	Crown – porcelain fused to high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2751	Crown – porcelain fused to predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2752	Crown – porcelain fused to noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2753	Crown – porcelain fused to titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D2780	Crown – 3/4 cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2781	Crown – 3/4 cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2782	Crown – 3/4 cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2783	Crown – 3/4 porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D2790	Crown – full cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2791	Crown – full cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2792	Crown – full cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D2794	Crown – titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$15	$15	*1 per 6 months; included at no additional cost within 12 months of placement by the same Dentist/office*	
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	Not a Benefit	$15		
D2920	Re-cement or re-bond crown	$15	$15	*1 per 6 months; included at no additional cost within 12 months of placement by the same Dentist/office*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2921	Reattachment of tooth fragment, incisal edge or cusp	Not a Benefit	$95		*Anterior tooth; 1 per 24 months*
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	$120	$120	*1 per 60 months; through age 14*	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$160	Not a Benefit	*1 per 60 months*	
D2930	Prefabricated stainless steel crown – primary tooth	$80	Not a Benefit	*1 per 60 months; through age 14*	
D2931	Prefabricated stainless steel crown – permanent tooth	$120	$120	*1 per 60 months; through age 14*	
D2940	Placement of interim direct restoration	$30	$15	*Included in fee for D3220-D3950 when performed on the same date by the same Dentist/dental office*	*Included in fee for D3220-D3950 when performed on the same date by the same Dentist/dental office*
D2949	Restorative foundation for an indirect restoration	Not a Benefit	$90		
D2950	Core buildup, including any pins when required	$90	$90	*1 per 60 months*	
D2951	Pin retention – per tooth, in addition to restoration	$25	$25		
D2952	Post and core in addition to crown, indirectly fabricated	Not a Benefit	$115		*Base metal post; includes canal preparation*
D2953	Each additional indirectly fabricated post – same tooth	Not a Benefit	$70		*Includes canal preparation*
D2954	Prefabricated post and core in addition to crown	$80	$80	*Includes canal preparation; 1 per 60 months*	*Includes canal preparation*
D2955	Post removal	Not a Benefit	$35		
D2956	Removal of an indirect restoration on a natural tooth	No cost	No cost		
D2957	Each additional prefabricated post – same tooth	Not a Benefit	$30		*Includes canal preparation*
D2960	Labial veneer (resin laminate) – direct	Not a Benefit	$300		*Limited to replacement of significant tooth structure loss due to caries or fracture*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2961	Labial veneer (resin laminate) – indirect	Not a Benefit	$340		*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2962	Labial veneer (porcelain laminate) – indirect	Not a Benefit	$400		*Limited to replacement of significant tooth structure loss due to caries or fracture*
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	Not a Benefit	$100		
D2976	Band stabilization – per tooth	$50	$40	*1 per tooth per lifetime*	*1 per tooth per lifetime*
D2980	Crown repair necessitated by restorative material failure	$110	$110		
D2981	Inlay repair necessitated by restorative material failure	$110	$110		
D2982	Onlay repair necessitated by restorative material failure	$110	$110		
D2983	Veneer repair necessitated by restorative material failure	$110	$110		
D2989	Excavation of a tooth resulting in the determination of non-restorability	Not a Benefit	No cost		
D2990	Resin infiltration of incipient smooth surface lesions	$5	Not a Benefit	*1 per 36 months*	
D3000-D3999 IV. ENDODONTICS					
D3110	Pulp cap – direct (excluding final restoration)	Not a Benefit	$20		
D3120	Pulp cap – indirect (excluding final restoration)	Not a Benefit	$20		
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$40	Not a Benefit	*If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure*	
D3221	Pulpal debridement, primary and permanent teeth	Not a Benefit	$40		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	$50	Not a Benefit	*If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure*	
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$50	Not a Benefit	*1 per tooth per lifetime; primary incisor up to age 6, primary molars up to age 11*	
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$50	Not a Benefit	*1 per tooth per lifetime; primary incisor up to age 6, primary molars up to age 11*	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$170	$170	*Root canal*	*Root canal*
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$190	$190	*Root canal*	*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$240	$240	*Root canal*	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$170	$170		
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$90	$90		
D3333	Internal root repair of perforation defects	$140	$115		
D3346	Retreatment of previous root canal therapy – anterior	$350	$350		
D3347	Retreatment of previous root canal therapy – premolar	$350	$350		
D3348	Retreatment of previous root canal therapy – molar	$350	$350		
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$140	Not a Benefit		
D3352	Apexification/recalcification – interim medication replacement	$140	Not a Benefit		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	$290	Not a Benefit		
D3355	Pulpal regeneration – initial visit	$115	Not a Benefit		
D3356	Pulpal regeneration – interim medication replacement	$58	Not a Benefit		
D3357	Pulpal regeneration – completion of treatment	$58	Not a Benefit		
D3410	Apicoectomy – anterior	$170	$170		
D3421	Apicoectomy – premolar (first root)	$170	$170		
D3425	Apicoectomy – molar (first root)	$250	$250		
D3426	Apicoectomy (each additional root)	$100	$100		
D3430	Retrograde filling – per root	No cost	$60		
D3450	Root amputation – per root	$120	$120		
D3471	Surgical repair of root resorption – anterior	$170	$170		
D3472	Surgical repair of root resorption – premolar	$170	$170		
D3473	Surgical repair of root resorption – molar	$170	$170		
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	$170	$170		
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	$170	$170		
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	$170	$170		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3911	Intraorifice barrier	No cost	No cost	*Included in case by Dentist/dental office who performed root canal; a separate charge applies for service provided by a Dentist other than the original treating Dentist/dental office*	*Included in case by Dentist/dental office who performed root canal; a separate charge applies for service provided by a Dentist other than the original treating Dentist/dental office*
D3920	Hemisection (including any root removal), not including root canal therapy	$120	$120		
D3921	Decoronation or submergence of an erupted tooth	$18	$18		
D3950	Canal preparation and fitting of preformed dowel or post	No cost	No cost		
D4000-D4999 V. PERIODONTICS					
– *Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.*					
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	$165	$165	*1 per 36 months per quadrant*	
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	$50	$50	*1 per 36 months per quadrant*	
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No cost	No cost	*1 per 36 months*	
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	$185	$185	*1 per 36 months per quadrant*	
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	$110	$110	*1 per 36 months per quadrant*	
D4245	Apically positioned flap	Not a Benefit	$135		
D4249	Clinical crown lengthening – hard tissue	$215	$215		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$350	$350	*1 per 36 months per quadrant*	
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$350	$350	*1 per 36 months per quadrant*	
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	$225	$190	*1 per 36 months*	
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	Not a Benefit	$105		
D4266	Guided tissue regeneration, natural teeth – resorbable barrier, per site	Not a Benefit	$210		
D4267	Guided tissue regeneration, natural teeth – non-resorbable barrier, per site	Not a Benefit	$240		
D4268	Surgical revision procedure, per tooth	$250	Not a Benefit		
D4270	Pedicle soft tissue graft procedure	$250	$250		
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$350	$350		
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	Not a Benefit	$105		
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$350	$350	*1 per 36 months*	
D4276	Combined connective tissue and pedicle graft, per tooth	$350	Not a Benefit	*1 per 36 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$245	$245		
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$245	$245		
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$210	$210		
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$210	$210	*1 per 36 months*	
D4286	Removal of non-resorbable barrier	Not a Benefit	No cost		
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$50	$50	*1 per quadrant per 24 months*	*1 per quadrant per 24 months*
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$40	$40	*1 per quadrant per 24 months*	*1 per quadrant per 24 months*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$5	$5	*Cleaning; 2 of (D1110, D1120, D4346) per Calendar Year*	*Cleaning; 2 of (D1110, D4346) per 12 months*
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$50	$50	*1 per lifetime*	*1 treatment per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	Not a Benefit	$60		*For each of the first two teeth treated within a quadrant following root planing or periodontal maintenance*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	Not a Benefit	No cost		*For an additional tooth treated in the same quadrant following root planing or periodontal maintenance*
D4910	Periodontal maintenance	$50	$50	*4 per 12 months combined with prophylaxis (D1110, D1120) after the completion of active periodontal therapy*	*2 per 12 months*
D4910	Periodontal maintenance	Not a Benefit	$70		*Up to 2 additional periodontal maintenances per 12 months*
D4920	Unscheduled dressing change (by someone other than treating Dentist or their staff)	$20	$15	*1 per Contract Dentist*	
D4921	Gingival irrigation with a medicinal agent – per quadrant	Not a Benefit	No cost		
D5000-D5899 VI. PROSTHODONTICS (removable)					
– *For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first three months after placement. You must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.*					
– *Replacement of a denture or a partial denture requires the existing denture to be 60+ months old.*					
D5110	Complete denture – maxillary	$350	$350	*1 per 60 months*	*1 per 60 months*
D5120	Complete denture – mandibular	$350	$350	*1 per 60 months*	*1 per 60 months*
D5130	Immediate denture – maxillary	$350	$350	*1 per 60 months*	*1 per 60 months*
D5140	Immediate denture – mandibular	$350	$350	*1 per 60 months*	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 per 60 months*	*1 per 60 months*
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 per 60 months*	*1 per 60 months*
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 per 60 months*	*1 per 60 months*
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 per 60 months*	*1 per 60 months*
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 per 60 months*	*1 per 60 months*
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 per 60 months*	*1 per 60 months*
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 per 60 months*	*1 per 60 months*
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$350	$350	*1 per 60 months*	*1 per 60 months*
D5225	Maxillary partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	Not a Benefit	$350		*1 per 60 months*
D5226	Mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	Not a Benefit	$350		*1 per 60 months*
D5227	Immediate maxillary partial denture – flexible base (including any clasps, rests and teeth)	Not a Benefit	$350		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5228	Immediate mandibular partial denture – flexible base (including any clasps, rests and teeth)	Not a Benefit	$350		*1 per 60 months*
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	$350	$350	*1 per 60 months*	*1 per 60 months*
D5283	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	$350	$350	*1 per 60 months*	*1 per 60 months*
D5284	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant	$315	$315	*1 per 60 months*	*1 per 60 months*
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) – per quadrant	$315	$315	*1 per 60 months*	*1 per 60 months*
D5410	Adjust complete denture – maxillary	$15	$15		
D5411	Adjust complete denture – mandibular	$15	$15		
D5421	Adjust partial denture – maxillary	$15	$15		
D5422	Adjust partial denture – mandibular	$15	$15		
D5511	Repair broken complete denture base, mandibular	$60	$60		
D5512	Repair broken complete denture base, maxillary	$60	$60		
D5520	Replace missing or broken teeth – complete denture - per tooth	$60	$60		
D5611	Repair resin partial denture base, mandibular	$60	$60		
D5612	Repair resin partial denture base, maxillary	$60	$60		
D5621	Repair cast partial framework, mandibular	$60	$60		
D5622	Repair cast partial framework, maxillary	$60	$60		
D5630	Repair or replace broken retentive clasping materials – per tooth	$70	$70		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5640	Replace missing or broken teeth – partial denture – per tooth	$60	$60		
D5650	Add tooth to existing partial denture – per tooth	$60	$60		
D5660	Add clasp to existing partial denture – per tooth	$70	$70		
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not a Benefit	$275		
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not a Benefit	$275		
D5710	Rebase complete maxillary denture	$180	$180	*1 per 36 months (6 months after initial placement)*	*1 per 12 months*
D5711	Rebase complete mandibular denture	Not a Benefit	$180		*1 per 12 months*
D5720	Rebase maxillary partial denture	$180	$180	*1 per 36 months (6 months after initial placement)*	*1 per 12 months*
D5721	Rebase mandibular partial denture	$180	$180	*1 per 36 months (6 months after initial placement)*	*1 per 12 months*
D5725	Rebase hybrid prosthesis	$180	$180	*1 per 36 months (6 months after initial placement)*	*1 per 12 months*
D5730	Reline complete maxillary denture (direct)	$75	$75	*1 per 36 months (6 months after initial placement)*	*1 per 12 months*
D5731	Reline complete mandibular denture (direct)	$75	$75	*1 per 36 months (6 months after initial placement)*	*1 per 12 months*
D5740	Reline maxillary partial denture (direct)	$75	$75	*1 per 36 months (6 months after initial placement)*	*1 per 12 months*
D5741	Reline mandibular partial denture (direct)	$75	$75	*1 per 36 months (6 months after initial placement)*	*1 per 12 months*
D5750	Reline complete maxillary denture (indirect)	$150	$150	*1 per 36 months (6 months after initial placement)*	*1 per 12 months*
D5751	Reline complete mandibular denture (indirect)	$150	$150	*1 per 36 months (6 months after initial placement)*	*1 per 12 months*
D5760	Reline maxillary partial denture (indirect)	$150	$150	*1 per 36 months (6 months after initial placement)*	*1 per 12 months*
D5761	Reline mandibular partial denture (indirect)	$150	$150	*1 per 36 months (6 months after initial placement)*	*1 per 12 months*
D5765	Soft liner for complete or partial removable denture – indirect	$150	$150	*1 per 36 months (6 months after initial placement)*	*1 per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	Not a Benefit	$265		*1 per 12 months*
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	Not a Benefit	$265		*1 per 12 months*
D5850	Tissue conditioning, maxillary	$40	$40		*1 per 12 months*
D5851	Tissue conditioning, mandibular	$40	$40		*1 per 12 months*
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS – Not Covered					
D6000-D6199 VIII. IMPLANT SERVICES					
– *Includes adjustments, if needed, for the first six months after placement, if You continue to be eligible and the service is provided at the Contract Dentist's facility where the implant was originally delivered.*					
– *Includes maintenance of an implant supported full arch fixed hybrid prosthesis when performed within 12 months of the insertion of the denture.*					
– *Includes replacement of an implant screw when performed within 6 months of the insertion of the implant or abutment supported prosthesis (crown, bridge or denture).*					
– *Replacement of a retainer, pontic, or stress breaker requires the existing bridge to be 60+ months old.*					
– *FPD, as referenced below, stands for fixed partial denture.*					
D6010	Surgical placement of implant body: endosteal implant	$350	Not a Benefit	*1 per 60 months*	
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$350	Not a Benefit	*1 per 60 months*	
D6040	Surgical placement: eposteal implant	$350	Not a Benefit	*1 per 60 months*	
D6050	Surgical placement: transosteal implant	$350	Not a Benefit	*1 per 60 months*	
D6055	Connecting bar – implant supported or abutment supported	$350	Not a Benefit	*1 per 60 months*	
D6056	Prefabricated abutment – includes modification and placement	$350	Not a Benefit	*1 per 60 months*	
D6057	Custom fabricated abutment – includes placement	$350	Not a Benefit	*1 per 60 months*	
D6058	Abutment supported porcelain/ceramic crown	$350	Not a Benefit	*1 per 60 months*	
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$350	Not a Benefit	*1 per 60 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6062	Abutment supported cast metal crown (high noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6063	Abutment supported cast metal crown (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6064	Abutment supported cast metal crown (noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6065	Implant supported porcelain/ceramic crown	$350	Not a Benefit	*1 per 60 months*	
D6066	Implant supported crown - porcelain fused to high noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6067	Implant supported crown - high noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6068	Abutment supported retainer for porcelain/ceramic FPD	$350	Not a Benefit	*1 per 60 months*	
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$350	Not a Benefit	*1 per 60 months*	
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$350	Not a Benefit	*1 per 60 months*	
D6075	Implant supported retainer for ceramic FPD	$350	Not a Benefit	*1 per 60 months*	
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6077	Implant supported retainer for metal FPD - high noble alloys	$350	Not a Benefit	*1 per 60 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	$60	Not a Benefit	*1 per 60 months*	
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	$110	Not a Benefit	*1 per 60 months*	
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	
D6083	Implant supported crown - porcelain fused to noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6085	Interim implant crown	No cost	Not a Benefit	*1 per 60 months*	
D6086	Implant supported crown - predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	
D6087	Implant supported crown - noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6088	Implant supported crown - titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6089	Accessing and retorquing loose implant screw - per screw	$170	Not a Benefit	*1 per tooth per 24 months*	
D6090	Repair implant/abutment supported prosthesis	$350	Not a Benefit	*1 per 24 months per tooth*	
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$60	Not a Benefit	*1 per 60 months*	
D6096	Remove broken implant retaining screw	$170	Not a Benefit	*1 per 24 months*	
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$350	Not a Benefit	*1 per 60 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6100	Surgical removal of implant body	$250	Not a Benefit	*1 per 60 months*	
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	$110	Not a Benefit	*1 per 60 months*	
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	$350	Not a Benefit	*1 per 60 months*	
D6103	Bone graft for repair of peri-implant defect – does not include flap entry and closure	$225	Not a Benefit		
D6104	Bone graft at time of implant placement	$225	Not a Benefit		
D6105	Removal of implant body not requiring bone removal or flap elevation	$18	Not a Benefit	*Included at no additional cost within 3 months of surgical placement of implant (D6010) by the same Contract Dentist/office; 1 per 60 months*	
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	$350	Not a Benefit	*1 per 60 months*	
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular	$350	Not a Benefit	*1 per 60 months*	
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	$350	Not a Benefit	*1 per 60 months*	
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	$350	Not a Benefit	*1 per 60 months*	
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary	$350	Not a Benefit	*1 per 60 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular	$350	Not a Benefit	*1 per 60 months*	
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	$350	Not a Benefit	*1 per 60 months*	
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	$350	Not a Benefit	*1 per 60 months*	
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350	Not a Benefit	*1 per 60 months*	
D6122	Implant supported retainer for metal FPD - noble alloys	$350	Not a Benefit	*1 per 60 months*	
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	$60	Not a Benefit	*1 of (D6080 or D6180) per 12 months per arch*	
D6190	Radiographic/surgical implant index, by report	$155	Not a Benefit	*1 per 60 months*	
D6193	Replacement of an implant screw	$60	Not a Benefit	*1 per 24 months*	
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$350	Not a Benefit	*1 per 60 months*	
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$60	Not a Benefit	*1 per 24 months*	
D6200-D6999 IX. PROSTHODONTICS, fixed					
– *Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge).*					
– *Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 60+ months old.*					
D6205	Pontic - indirect resin based composite	Not a Benefit	$245		*1 per 60 months*
D6210	Pontic - cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6211	Pontic - cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6212	Pontic - cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6214	Pontic - titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D6240	Pontic - porcelain fused to high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6241	Pontic - porcelain fused to predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6242	Pontic - porcelain fused to noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6243	Pontic - porcelain fused to titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D6245	Pontic - porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D6250	Pontic - resin with high noble metal	Not a Benefit	$350		*1 per 60 months*
D6251	Pontic - resin with predominantly base metal	Not a Benefit	$350		*1 per 60 months*
D6252	Pontic - resin with noble metal	Not a Benefit	$350		*1 per 60 months*
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$250	Not a Benefit	*1 per 60 months*	
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$350	Not a Benefit	*1 per 60 months*	
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$350	$350	*1 per 60 months*	*1 per 60 months*
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$350	$350	*1 per 60 months*	*1 per 60 months*
D6602	Retainer inlay - cast high noble metal, two surfaces	$350	$370	*1 per 60 months*	*1 per 60 months*
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$350	$380	*1 per 60 months*	*1 per 60 months*
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$350	$350	*1 per 60 months*	*1 per 60 months*
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$350	$350	*1 per 60 months*	*1 per 60 months*
D6606	Retainer inlay - cast noble metal, two surfaces	$350	$370	*1 per 60 months*	*1 per 60 months*
D6607	Retainer inlay - cast noble metal, three or more surfaces	$350	$380	*1 per 60 months*	*1 per 60 months*
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$350	$395	*1 per 60 months*	*1 per 60 months*
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$350	$415	*1 per 60 months*	*1 per 60 months*
D6610	Retainer onlay - cast high noble metal, two surfaces	$350	$370	*1 per 60 months*	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$350	$390	*1 per 60 months*	*1 per 60 months*
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$350	$350	*1 per 60 months*	*1 per 60 months*
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$350	$350	*1 per 60 months*	*1 per 60 months*
D6614	Retainer onlay - cast noble metal, two surfaces	$350	$370	*1 per 60 months*	*1 per 60 months*
D6615	Retainer onlay - cast noble metal, three or more surfaces	$350	$360	*1 per 60 months*	*1 per 60 months*
D6710	Retainer crown - indirect resin based composite	Not a Benefit	$245		*1 per 60 months*
D6720	Retainer crown - resin with high noble metal	Not a Benefit	$350		*1 per 60 months*
D6721	Retainer crown - resin with predominantly base metal	Not a Benefit	$350		*1 per 60 months*
D6722	Retainer crown - resin with noble metal	Not a Benefit	$350		*1 per 60 months*
D6740	Retainer crown - porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D6750	Retainer crown - porcelain fused to high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6751	Retainer crown - porcelain fused to predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6752	Retainer crown - porcelain fused to noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D6780	Retainer crown - 3/4 cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6781	Retainer crown - 3/4 cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6782	Retainer crown - 3/4 cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6783	Retainer crown - 3/4 porcelain/ceramic	$350	$350	*1 per 60 months*	*1 per 60 months*
D6784	Retainer crown - 3/4 titanium and titanium alloys	$350	$350	*1 per 60 months*	*1 per 60 months*
D6790	Retainer crown - full cast high noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6791	Retainer crown - full cast predominantly base metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6792	Retainer crown - full cast noble metal	$350	$350	*1 per 60 months*	*1 per 60 months*
D6794	Retainer crown – titanium and titanium alloys	Not a Benefit	$350		*1 per 60 months*
D6930	Re-cement or re-bond fixed partial denture	$40	$40		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6940	Stress breaker	Not a Benefit	$100		
D6980	Fixed partial denture repair necessitated by restorative material failure	$140	$140		
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY					
– *Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.*					
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$18	$18		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$40	$30		
D7220	Removal of impacted tooth - soft tissue	$65	$50		
D7230	Removal of impacted tooth - partially bony	$85	$65		
D7240	Removal of impacted tooth - completely bony	$120	$80		
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$150	$150		
D7250	Removal of residual tooth roots (cutting procedure)	$135	$135		
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	$150	$135		
D7252	Partial extraction for immediate implant placement	Not a Benefit	$30		*1 per lifetime*
D7259	Nerve dissection	No cost	No cost		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$70	$70		
D7280	Exposure of an unerupted tooth	$115	$115		
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Not a Benefit	$110		
D7283	Placement of device to facilitate eruption of impacted tooth	Not a Benefit	$110		
D7284	Excisional biopsy of minor salivary glands	Not a Benefit	$100		
D7286	Incisional biopsy of oral tissue -soft	Not a Benefit	$100		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$40	$40		
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$40	$40		
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$60	$60		
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$60	$60		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	Not a Benefit	$60		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	Not a Benefit	$90		
D7471	Removal of lateral exostosis (maxilla or mandible)	$65	$65		
D7472	Removal of torus palatinus	Not a Benefit	$65		
D7473	Removal of torus mandibularis	Not a Benefit	$65		
D7509	Marsupialization of odontogenic cyst	Not a Benefit	$90		
D7510	Incision and drainage of abscess - intraoral soft tissue	$60	$60		
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$85	$85		
D7910	Suture of recent small wounds up to 5 cm	$40	Not a Benefit		
D7921	Collection and application of autologous blood concentrate product	$100	Not a Benefit	*1 per 36 months*	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No cost	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7953	Bone replacement graft for ridge preservation - per site	$200	Not a Benefit	*1 per tooth per lifetime*	
D7961	Buccal/labial frenectomy (frenulectomy)	Not a Benefit	$160		
D7962	Lingual frenectomy (frenulectomy)	Not a Benefit	$160		
D7970	Excision of hyperplastic tissue - per arch	Not a Benefit	$115		
D7971	Excision of pericoronal gingiva	$90	$90		
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees ONLY					
– *Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when prior Authorization is obtained. The prior Authorization determination will be provided to the Dentist within three (3) calendar days of Our receipt of the request. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.*					
– *Pediatric Enrollee must continue to be eligible, Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.*					
– *Comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to You is permitted except for services provided by an orthodontist other than the original treating Contract Dentist or dental office.*					
– *Limited orthodontic treatment (any dentition) and comprehensive orthodontic treatment (any dentition) are part of comprehensive orthodontic treatment with orthognathic surgery.*					
– *Refer to Schedule B for Limitations and Exclusions for medically necessary orthodontics for additional information.*					
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350	N/A		
D8090	Comprehensive orthodontic treatment of the adult dentition	$350	N/A		
D8091	Comprehensive orthodontic treatment with orthognathic surgery	$410	N/A		
D8660	Pre-orthodontic treatment examination to monitor growth and development	$51	N/A	*1 per 6 months when performed by the same Contract Dentist or dental office*	
D8670	Periodic orthodontic treatment visit	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office who was paid for banding*	
D8681	Removable orthodontic retainer adjustment	No cost	N/A		
D8698	Re-cement or re-bond fixed retainer – maxillary	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	
D8699	Re-cement or re-bond fixed retainer – mandibular	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	
D8701	Repair of fixed retainer, includes reattachment – maxillary	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8702	Repair of fixed retainer, includes reattachment – mandibular	No cost	N/A	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*	
D8000-D8999 XI. ORTHODONTICS – for Adult Enrollees (age 19 and up)					
– *Including covered dependent adult children. You must continue to be eligible during active treatment.*					
– *Limited orthodontic treatment (any dentition) and comprehensive orthodontic treatment (any dentition) are part of comprehensive orthodontic treatment with orthognathic surgery.*					
– *The listed Copayment for each phase of orthodontic treatment (limited or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.*					
Pre and post orthodontic records include:					
The Benefit for pre-treatment records and diagnostic services includes:		N/A	$250		
D0210	Intraoral - comprehensive series of radiographic images	N/A	Included		
D0322	Tomographic survey	N/A	Included		
D0330	Panoramic radiographic image	N/A	Included		
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	N/A	Included		
D0350	2D oral/facial photographic image obtained intraorally or extraorally	N/A	Included		
D0470	Diagnostic casts	N/A	Included		
D0701	Panoramic radiographic image - image capture only	N/A	Included		
D0702	2D cephalometric radiographic image - image capture only	N/A	Included		
D0703	2D oral/facial photographic image obtained intraorally or extraorally - image capture only	N/A	Included		
D0709	Intraoral - comprehensive series of radiographic images - image capture only	N/A	Included		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
The Benefit for post-treatment records includes:		N/A	$70		
D0210	Intraoral - comprehensive series of radiographic images	N/A	Included		
D0470	Diagnostic casts	N/A	Included		
D0709	Intraoral - comprehensive series of radiographic images - image capture only	Not a Benefit	Included		
D8040	Limited orthodontic treatment of the adult dentition	N/A	$1,950		
D8080	Comprehensive orthodontic treatment of the adolescent dentition	N/A	$3,250		
D8090	Comprehensive orthodontic treatment of the adult dentition	N/A	$3,250		
D8091	Comprehensive orthodontic treatment with orthognathic surgery	N/A	$3,740		
D8660	Pre-orthodontic treatment examination to monitor growth and development	N/A	$51		*1 per 6 months when performed by the same Contract Dentist or dental office*
D8670	Periodic orthodontic treatment visit	N/A	No cost		*Included in comprehensive case fee*
D8671	Periodic orthodontic treatment visit (included in comprehensive orthodontic case fee)	N/A	No cost		*Included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	N/A	$450		*Placement of removable retainers*
D8681	Removable orthodontic retainer adjustment	N/A	No cost		
D8698	Re-cement or re-bond fixed retainer – maxillary	N/A	No cost		*2 per 6 months*
D8699	Re-cement or re-bond fixed retainer - mandibular	N/A	No cost		*2 per 6 months*
D8701	Repair of fixed retainer, includes reattachment – maxillary	N/A	No cost		*2 per 6 months*
D8702	Repair of fixed retainer, includes reattachment - mandibular	N/A	No cost		*2 per 6 months*
D8999	Unspecified orthodontic procedure, by report	N/A	$250		*Includes treatment planning session*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES					
D9110	Palliative treatment of dental pain – per visit	$30	$35		
D9211	Regional block anesthesia	Not a Benefit	No cost		
D9212	Trigeminal division block anesthesia	Not a Benefit	No cost		
D9215	Local anesthesia in conjunction with operative or surgical procedures	Not a Benefit	No cost		
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	Not a Benefit	No cost		
D9222	Deep sedation/general anesthesia - first 15 minutes	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$100	$100	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9310	Consultation - diagnostic service provided by Dentist or physician other than requesting Dentist or physician	$35	$35		
D9311	Consultation with a medical health care professional	No cost	No cost		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$10	$10		
D9440	Office visit - after regularly scheduled hours	$35	$35		
D9450	Case presentation, subsequent to detailed and extensive treatment planning	Not a Benefit	$10		
D9610	Therapeutic parenteral drug, single administration	$40	Not a Benefit		
D9912	Pre-visit patient screening	No cost	No cost		
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$45	Not a Benefit		
D9932	Cleaning and inspection of removable complete denture, maxillary	No cost	No cost		*No limit (included in fee for D1110, D4346 and D4910 on the same date of service)*
D9933	Cleaning and inspection of removable complete denture, mandibular	No cost	No cost		*No limit (included in fee for D1110, D4346 and D4910 on the same date of service)*
D9934	Cleaning and inspection of removable partial denture, maxillary	No cost	No cost		*No limit (included in fee for D1110, D4346 and D4910 on the same date of service)*
D9935	Cleaning and inspection of removable partial denture, mandibular	No cost	No cost		*No limit (included in fee for D1110, D4346 and D4910 on the same date of service)*
D9943	Occlusal guard adjustment	$10	$15	*1 per 12 months (6 months after initial placement)*	*1 per 12 months (6 months after initial placement)*
D9944	Occlusal guard – hard appliance, full arch	$270	$270	*1 of (D9944, D9945, D9946) per 12 months; age 13 and up*	*1 of (D9944, D9945, D9946) per 36 months*
D9945	Occlusal guard – soft appliance, full arch	$70	$70	*1 of (D9944, D9945, D9946) per 12 months; age 13 and up*	*1 of (D9944, D9945, D9946) per 36 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9946	Occlusal guard – hard appliance, partial arch	$135	$135	*1 of (D9944, D9945, D9946) per 12 months; age 13 and up*	*1 of (D9944, D9945, D9946) per 36 months*
D9951	Occlusal adjustment - limited	Not a Benefit	$65		
D9952	Occlusal adjustment - complete	Not a Benefit	$265		*1 per 36 months*
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	Not a Benefit	$125		*Limited to one bleaching tray and gel for two weeks of self-treatment*
D9986	Missed appointment	$50	$50	*Without 24 hour notice*	*Without 24 hour notice*
D9987	Cancelled appointment	$50	$50	*Without 24 hour notice*	*Without 24 hour notice*
D9995	Teledentistry - synchronous; real-time encounter	No cost	No cost		
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No cost	No cost		
D9997	Dental case management - patients with special health care needs	No cost	No cost		

Endnotes:

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

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

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

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

If services for a listed procedure are performed by the Contract Dentist, You pay the specified Copayment(s). Listed procedures which require a Dentist to provide Specialized Services, and are referred by the Contract Dentist, must be authorized by Us. You pay the Copayment(s) specified for such services.

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

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

Limitations and Exclusions of Benefits for Adult Enrollees (Age 19 and Older)

Limitations of Benefits for Adult Enrollees:

1. The frequency of certain Benefits is limited. Frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If You accept a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, You may be charged an additional $125.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions (Procedures D7230, D7240, and D7241).
4. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. Contract Dentists may offer services that utilize brand or trade names at an additional fee. You must be offered the plan Benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If You choose the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Contact the Customer Service Center at 888-857-0337 if You have questions regarding the additional fee or name brand services.
5. Benefits for a soft tissue management program are limited to those parts which are listed covered services listed on *Schedule A, Description of Benefits and Copayments*. If You decline non-covered services within a soft tissue management program, it does not eliminate or alter other covered Benefits.
6. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's submitted fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. You make payment directly to the Contract Orthodontist as arranged.

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

   a. for 60 days after the date coverage terminates if the Contract Orthodontist has agreed to or is receiving monthly payments; or
   b. until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Contract Orthodontist has agreed to accept or is receiving payments on a quarterly basis.
7. Coverage for orthodontic treatment is limited to conventional orthodontic services, which includes clear aligner therapy (e.g., Invisalign™ and Sure Smile™). We consider lingual brackets, clear (composite or ceramic) brackets to be Specialized Services. When treatment using lingual brackets or clear (composite or ceramic) brackets is provided, We will make an allowance for conventional orthodontic services. You are responsible for Your Copayment for the conventional orthodontic treatment plus the additional fees related to the Specialized Services (lingual brackets or clear brackets).

8. Benefits for dental expenses incurred in connection with any dental or orthodontic procedure started before Your eligibility with this plan are limited as follows:

   a. Upon request of a newly covered Enrollee, We will provide Benefits for the completion of covered services begun prior to the time the Enrollee's coverage became effective. We will not provide coverage for incomplete services that are not otherwise Benefits under the terms and conditions of the Contract. You may request completion of treatment in progress by calling the Customer Service Center at 888-857-0337 during normal business hours, or by sending a written request to Us.

   b. Whenever possible, You should complete treatment in progress with the Dentist who initiated the service. If such Dentist is an Out-of-Network Dentist, that Dentist must agree to the same terms and conditions that apply to an in-network Dentist in order for Us to provide Benefits. Copayments and other cost sharing components will apply. Benefits may be adjusted so that the total paid by You and/or coverage provided by all plans is not more that 100% of total Allowable Expenses. Allowable expense is the necessary, reasonable, and customary item of expense, including coinsurance or Copayments and without reduction for any applicable deductible, for dental care when the item of expense is covered.

   c. Should You be unable to complete treatment with the Dentist who initiated the service, We will make reasonable and appropriate arrangements for completion of such treatment by a Contract Dentist.

Exclusions of Benefits for Adult Enrollees:

1. any procedure that is not specifically listed as a covered Benefit under *Schedule A*, *Description of Benefits and Copayments*.
2. any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.
3. services solely for cosmetic purposes, with the exception of procedure D9975 (external bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
4. lost, stolen or broken appliances including, but not limited to, full or partial dentures, crowns, fixed partial dentures (bridges), orthodontic and other appliances.
5. procedures, appliances or restoration if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), with the exception of procedures shown on *Schedule A*.
6. precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
7. implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
8. consultations or other diagnostic services for non-covered Benefits.
9. dental services received from any dental facility other than the Contract Dentist or an authorized dental specialist (oral surgeon, endodontist, periodontist, pediatric Dentist or Contract Orthodontist) except for *Emergency Dental Services* as described in the Contract.
10. all related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
11. prescription and over-the-counter drugs.
12. changes in orthodontic treatment necessitated by accident of any kind.

13. myofunctional and parafunctional appliances and/or therapies, with the exception of procedures shown on *Schedule A.*

14. treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

15. orthodontics, including oral evaluations and all treatment, must be performed by a licensed Dentist or their supervised staff, acting within the scope of applicable law. The Dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan. All orthodontic services, including direct to consumer orthodontics, must be provided by a licensed Dentist authorized to deliver care in Your state. Claims for services that are not provided by a Dentist are not eligible for reimbursement.

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

17. cone beam image capture only.

18. services or supplies for sleep apnea.

Limitations and Exclusions of Benefits for Pediatric Enrollees (Under Age 19)

Limitations of Benefits for Pediatric Enrollees:

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

1. Isolated bitewing or periapical images are allowed on an emergency or episodic basis.

2. Additional coverage of panoramic and cephalometric images (D0330, D0340, D0701, D0702) is allowed as part of an initial medically necessary orthodontic treatment or on an emergency basis.

3. Sealants (D1351, D1352) are covered only on permanent molars. The teeth must be caries free with no restorations on the mesial, distal or occlusal surfaces.

4. Repair or replacement of restorations by the same Dentist and involving the same tooth surfaces, performed within 24 months of the original restoration are included, and a separate fee is not chargeable to You by a Contract Dentist. However, coverage may be allowed if the repair or replacement is due to fracture of the tooth or the restoration involves the occlusal surface of a posterior tooth or the lingual surface of an anterior tooth and is placed following root canal therapy.

5. Covered restorations includes all related services including, but not limited to, etching, bases, liners, dentinal adhesives, local anesthesia, polishing, caries removal, preparation of gingival tissue, occlusal/contact adjustments, and detection agents.

6. Resin restoration is a Benefit when a laboratory fabricated porcelain or resin veneer is used to restore any teeth due to tooth fracture or caries.

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

8. Placement of interim direct restoration is included in the fee for the following covered endodontic procedures (D3220-D3950) when performed on the same date by the same Dentist/dental office,

9. Onlays, permanent single crown restorations, and posts and cores for Enrollees 12 years of age or younger are excluded from coverage, unless specific rationale is provided indicating the reason for such treatment (e.g., fracture, endodontic therapy, etc.) and is approved by Us.

10. Core buildups (D2950) can be considered for Benefits only when there is insufficient retention for a crown. A buildup should not be reported when the procedure only involves a filler used to eliminate undercuts, box forms or concave irregularities in the preparation.

11. Replacement of crowns, inlays, onlays, buildups, and posts and cores is covered only if the existing crown, inlay, onlay, buildup, or post and core was inserted at least 60 months prior to the replacement and satisfactory evidence is presented that the existing crown, inlay, onlay, buildup, or post and core is not and cannot be made serviceable. The 60-month service date is measured based on the actual date (day and month) of the initial service versus the first day of the initial service month.

12. Onlays, crowns, and posts and cores are covered only when necessary due to decay or tooth fracture. However, if the tooth can be adequately restored with amalgam or composite (resin) filling material, coverage is for that service. Crowns, inlays, onlays, buildups, or posts and cores, begun prior to the effective date of coverage or cemented after the cancellation date of coverage, are not eligible for coverage.

13. Recement or re-bond of prefabricated and cast crowns, bridges, onlays, inlays, and posts is provided within 12 months of placement by the same Dentist is included at no additional cost to You.

14. Posts are only covered when provided as part of a buildup for a crown. When performed as an independent procedure, the placement of a post is not a covered Benefit.

15. Pulpotomies are included when performed by the same Dentist within a 45-day period prior to the completion of root canal therapy.

    a. A pulpotomy is covered when performed as a final endodontic procedure and is covered generally on primary teeth only. Pulpotomies performed on permanent teeth are included to root canal therapy and are not reimbursable unless specific rationale is provided and root canal therapy is not and will not be provided on the same tooth.

    b. Pulpotomies performed on permanent teeth are included to root canal therapy and are not reimbursable unless specific rationale is provided and root canal therapy is not and will not be provided on the same tooth.

16. Incomplete endodontic therapy is not a covered Benefit when due to Your discontinuing treatment.

17. For reporting and Benefit purposes, the completion date for endodontic therapy is the date the tooth is sealed.

18. Subepithelial connective tissue grafts and combined connective tissue and double pedicle grafts are covered at the level of free soft tissue grafts.

19. A single site for reporting osseous grafts consists of one contiguous area, regardless of the number of teeth (e.g., crater) or surfaces involved. Another site on the same tooth is included to the first site reported. Non-contiguous areas involving different teeth may be reported as additional sites.

20. Up to four periodontal maintenance procedures and up to two routine prophylaxes may be covered within a 12 consecutive month period, but the total of periodontal maintenance and routine prophylaxes may not exceed four procedures in a 12-month period.

    a. Periodontal maintenance is only covered when performed following active periodontal treatment.

b. An oral evaluation reported in addition to periodontal maintenance will be covered as a separate procedure subject to the Contract and limitations applicable to oral evaluations.

21. Coverage for multiple periodontal surgical procedures (except soft tissue grafts and osseous grafts) provided in the same area of the mouth during the same course of treatment is based on the fee for the greater surgical procedure.

22. Charges for related services such as necessary wires and splints, adjustments, and follow up visits are included to the fee for reimplantation and/or stabilization.

23. Routine postoperative care such as suture removal is included to the fee for the surgery.

24. The removal of impacted teeth is covered based on the anatomical position as determined from a review of images. If the degree of impaction is determined to be less than the reported degree, coverage will be based on the allowance for the lesser level.

25. Removal of impacted third molars in Enrollees under age 15 is not covered unless specific documentation is provided that substantiates the need for removal and is approved by Us.

26. For reporting and Benefit purposes, the completion date for crowns and fixed partial dentures is the cementation date. The completion date is the insertion date for removable prosthodontic appliances. For immediate dentures, however, the Dentist who fabricated the dentures may be reimbursed for the dentures after insertion if another Dentist, typically an oral surgeon, inserted the dentures.

27. Removable cast base partial dentures for Enrollees under 12 years of age are excluded from coverage unless specific rationale is provided indicating the necessity for that treatment and is approved by Us.

28. Recement or re-bond of prefabricated and cast crowns, bridges, onlays, inlays, and posts is eligible once per 6-month period. Recement or re-bond provided within 12 months of placement by the same Dentist is included at no additional cost to You.

29. With the exception of a new immediate denture, relining or rebasing is covered at no additional cost to You within six months of a denture's initial delivery.

30. Coverage for a denture made with precious metals is based on the allowance for a conventional denture.

31. A removable partial denture to replace all missing teeth in the arch is the Benefit.

32. Precision attachments, personalization, precious metal bases, and other specialized techniques are not covered Benefits.

33. Replacement of removable prostheses and fixed prostheses is covered only if the existing removable and/or fixed prostheses was inserted at least 60 months prior to the replacement and satisfactory evidence is presented that the existing removable and/or fixed prostheses cannot be made serviceable. Satisfactory evidence must show that the existing removable prostheses and/or fixed prostheses cannot be made serviceable. The 60-month service date is measured based on the actual date (day and month) of the initial service versus the first day of the initial service month.

34. Implants and related prosthetics may be covered and may be reimbursed as an alternative Benefit as a three unit fixed partial denture (FPD).

35. The fee for accessing and retorquing a loose implant screws is included in the fee for the delivery of the implant supported prosthesis, when performed within 6 months of the placement of the prosthesis.

36. Replacement of appliances including, but not limited to, full or partial dentures, space maintainers, crowns and prostheses that have been lost, stolen, or misplaced is not a covered service.

37. Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) only when provided in connection with a covered procedure(s) and when rendered by a

Dentist or other professional licensed Dentist and approved to provide anesthesia in the state where the service is rendered.

38. Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) when determined to be medically or dentally necessary for documented handicapped or uncontrollable Enrollees or justifiable medical or dental conditions.

39. In order for deep sedation/general anesthesia and intravenous conscious sedation to be covered, the procedure for which it was provided must be submitted. Services submitted without a report will be denied as a non-covered Benefit.

40. For palliative treatment to be covered; it must involve a problem or symptom that occurred suddenly and unexpectedly that requires immediate attention. The Dentist must provide treatment to alleviate Your problem. If the only service provided is to evaluate You and refer to another Dentist and/or prescribe medication, it would be considered a limited oral evaluation - problem focused.

41. Consultations are covered only when provided by a Dentist other than the practitioner providing the treatment.

42. After hours visits are covered only when the Dentist must return to the office after regularly scheduled hours to treat You in an emergency situation.

43. Therapeutic drug injections are only covered in unusual circumstances, which must be documented by report. They are not Benefits if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication.

44. Occlusal guards are covered by report for Enrollees 13 years of age or older when the purpose of the occlusal guard is the treatment of bruxism and must be prior authorized.

Exclusions of Benefits for Pediatric Enrollees:

Except as specifically provided, the following services, supplies, or charges are not covered:

1. any dental service or treatment not specifically listed under *Schedule A*, *Description of Benefits and Copayments*, as a covered service.

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

3. those not prescribed by or under the direct supervision of a Dentist, except in those states where dental hygienists are permitted to practice without supervision by a Dentist. In these states, We will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of the dental hygienist's license and applicable state law.

4. any procedure that has a poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with meeting accepted standards of dental practice.

5. those incurred after the termination date of Your coverage unless otherwise indicated.

6. those which are not medically or dentally necessary, or which are not recommended or approved by the treating Dentist. (Services determined to be unnecessary or which do not meet accepted standards of dental practice are not billable to You by a Contract Dentist unless the Dentist notifies You of the liability prior to treatment and You choose to receive the treatment. Contract Dentists should document such notification in their records.)

7. services or treatment provided by a member of Your immediate family.

8. those services submitted by a Dentist which are for the same services performed on the same date for the same Enrollee by another Dentist.

9. those which are experimental or investigative (deemed unproven).

10. those which are for unusual procedures and techniques and may not be considered generally accepted practices by the American Dental Association.
11. consultations or other diagnostic services for non-covered Benefits.
12. telephone consultations.
13. all related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
14. prescription and over-the-counter drugs.
15. preparations that can be used at home, such as fluoride gels, special mouth rinses (including antimicrobials), etc.
16. those which are for any illness or bodily injury which occurs in the course of employment if Benefits or compensation is available, in whole or in part, under the provision of any legislation of any governmental unit. This exclusion applies whether or not You claim the Benefits or compensation.
17. those which are later recovered in a lawsuit or in a compromise or settlement of any claim, except where prohibited by law.
18. those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.
19. those for which You would have no obligation to pay in the absence of this or any similar coverage.
20. those received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.
21. services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary orthodontics provided prior Authorization is obtained.
22. those performed by a Dentist who is compensated by a facility for similar covered services performed for Enrollees.
23. those resulting from Your failure to comply with professionally prescribed treatment.
24. any charges for failure to keep a scheduled appointment.
25. duplicate and temporary devices, appliances, and services.
26. any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.
27. services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJD).
28. services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
29. treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is covered under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
30. treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization.
31. services or treatment provided as a result of intentionally self-inflicted injury or illness.
32. services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection.
33. treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

34. charges for copies of Enrollees' records, charts or images, or any costs associated with forwarding/mailing copies of Enrollees' records, charts or images.

35. state or territorial taxes on dental services performed.

36. adjunctive dental services as defined by applicable federal regulations. These are medical services that may be covered under a medical policy even when provided by a general Dentist or oral surgeon.

    a. Adjunctive dental care is dental care that is:

        i. medically necessary in the treatment of an otherwise covered medical (not dental) condition.

        ii. an integral part of the treatment of such medical condition.

        iii. essential to the control of the primary medical condition.

        iv. required in preparation for or as the result of dental trauma, which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic).

    b. The following diagnoses or conditions may fall under this category:

        i. treatment for relief of Myofascial Pain Dysfunction Syndrome (MFPS) or Temporomandibular Joint Dysfunction (TMJD).

        ii. orthodontic treatment for cleft lip or cleft palate, or when required in preparation for, or as a result of, trauma to teeth and supporting structures caused by medically necessary treatment of an injury or disease.

        iii. procedures associated with preventive and restorative dental care when associated with radiation therapy to the head or neck unless otherwise covered as a routine preventive procedure under this plan.

        iv. treatment of total or complete ankyloglossia.

        v. treatment of an extraoral abscess or intraoral abscess that extends beyond the dental alveolus.

        vi. treatment of cellulitis and osteitis, which is clearly exacerbating and directly affecting a medical condition currently under treatment.

        vii. removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.

        viii. prosthetic replacement of either the maxilla or mandible due to reduction of body tissues associated with traumatic injury (such as a gunshot wound) in addition to services related to treating neoplasms or iatrogenic dental trauma.)

37. cone beam image capture only.

38. services or supplies for sleep apnea.

Policies, Limitations, and Exclusions for Medically Necessary Orthodontic Services for Pediatric Enrollees:

1. Services are limited to medically necessary orthodontics when provided by a Contract Dentist. Orthodontic treatment is a Benefit of this plan only when medically necessary as evidenced by a severe handicapping malocclusion for Pediatric Enrollees and must be prior authorized by Us.

2. Orthodontic procedures are a Benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.

3. The automatic qualifying conditions are:

a. cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist must be submitted, on their professional letterhead, with the prior Authorization request;

b. a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate;

c. a crossbite of individual anterior teeth causing destruction of soft tissue;

d. severe traumatic deviation.

4. The following documentation must be submitted to Us with the request for prior Authorization of services by the Contract Dentist:

- ADA 2006 or newer claim form with service code(s) requested;
- diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
- cephalometric radiographic image or panoramic radiographic image;
- HLD score sheet completed and signed by the orthodontist; and
- treatment plan.

5. The allowances for comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to You is permitted.

6. Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original treating orthodontist.

7. Orthodontic procedures are Benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Pediatric Enrollees and must be prior authorized.

8. Only those cases with permanent dentition will be considered for medically necessary handicapping malocclusion, unless the Enrollee is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a Benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

9. All necessary procedures that may affect orthodontic treatment must be completed before orthodontic treatment is considered.

10. When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, We will make an allowance for the cost of a standard orthodontic treatment.

11. Repair and replacement of an orthodontic appliance inserted under the plan that has been damaged, lost, stolen, or misplaced is not a covered service.

12. Should Your coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, You will be solely responsible for payment for treatment provided after cancellation or termination, except:

If You are receiving ongoing orthodontic treatment at the time of termination, We will continue to provide orthodontic Benefits for:

a. for 60 days if You are making monthly payments to the Contract Orthodontist; or

b. until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if You are making quarterly payments to the Contract Orthodontist.

At the end of 60 days (or at the end of the quarter), Your obligation will be based on the Contract Orthodontist's submitted fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. You will make payments based on an arrangement with the Contract Orthodontist.

13. Orthodontics, including oral evaluations and all treatment, must be performed by a licensed Dentist or his or her supervised staff, acting within the scope of applicable law. The Dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan. All orthodontic services, including direct to consumer orthodontics, must be provided by a licensed Dentist authorized to deliver care in Your state. Claims for services that are not provided by a Dentist are not eligible for reimbursement.

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

HIPAA Notice of Privacy Practices

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

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

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

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

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

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

PERMITTED USES AND DISCLOSURES OF YOUR PHI

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

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

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

Permitted uses and disclosures without an authorization

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

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

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

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

Disclosures made with your authorization

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

YOUR RIGHTS REGARDING PHI

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONTACTS

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

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Non-Discrimination Disclosure

Discrimination is Against the Law

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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



deltadentalins.com

ENROLLEE NOTICES

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

Federal Notices:

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

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

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

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

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

State Notices:

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

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

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

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

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

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330

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