DELTA DENTAL®

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

Delta Dental Individual & Family™

Delta Dental PPO™
Preferred Plan for Families

Combined Policy and Disclosure Form

Provided by:

Delta Dental Insurance Company
300 Corporate Center Dr. Ste 600
Camp Hill, PA 17011-1744

Limited Benefits, Please Read Carefully

www.deltadentalins.com

https://dchealthlink.com

855-532-5465

XIP-DC-ENT-26

Policy

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

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

LIMITED BENEFITS, READ YOUR POLICY AND ATTACHMENTS CAREFULLY

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

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

This Policy is signed for Delta Dental Insurance Company 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 Delta Dental PPO™ dental plan. Our goal is to provide You with the highest quality dental care and to help You maintain good dental health. We encourage You not to wait until You have a problem to see the dentist, but to see them on a regular basis.

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

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

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

Using This Policy

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

Contact Us

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

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

Delta Dental Insurance Company
P.O. Box 2105
Mechanicsburg, PA 17055-2105

Identification Number

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

DEFINITIONS

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

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

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

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

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

Civil Union: a same-sex relationship similar to marriage that is recognized as a Civil Union by the District of Columbia.

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

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

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

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

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

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

Domestic Partner: an unmarried person of the same or opposite sex who resides with the Primary Enrollee and has registered in a state or local Domestic Partner registry with the Primary Enrollee.

Effective Date: the original date the plan starts.

Eligible Dependent: a person who is a dependent, Spouse, partner, domestic partner or civil union partner of an Eligible Primary and considered to be a Qualified Individual by the Exchange. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption, and children of Spouse or civil union partner. Eligible Dependents are eligible for either Pediatric Benefits or Adult Benefits as described in this Policy. An Eligible Dependent's coverage under this Policy will terminate at the end of the Calendar Year during which the Dependent turns age 26.

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

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

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

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

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

Exchange: the District of Columbia Exchange also referred to as the "DC Health Benefit Exchange Authority."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Qualifying Status Change:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step 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.

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.

Spouse: a person of the same or opposite sex who is legally married to the Primary Enrollee:

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

Throughout this Policy, the term "Spouse" includes the definitions of Civil Union and Domestic Partner.

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

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

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

ELIGIBILITY AND ENROLLMENT

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

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

Eligibility Requirement for Pediatric Benefits

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

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

Pediatric Enrollees eligible for Pediatric Benefits are:

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

Eligibility Requirement for Adult Benefits

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

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

Adult Enrollees eligible for Adult Benefits are:

- a Primary Enrollee age 19 years of age or older; and/or
- a Primary Enrollee's Spouse or civil union partner age 19 and older and dependent children from age 19 to age 26. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption, and children of Spouse or civil union partner.

A dependent unmarried child 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, Spouse or civil union partner for support; and
- proof of dependent's 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 this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Primary Enrollee or Spouse for support because of a mental or physical disability that began before they reached the limiting age.

Renewal

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

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

Termination of Coverage

The Primary Enrollee has the right to terminate coverage under this Policy by contacting the DC HealthLink 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 Policy 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 Policy;
- non-payment of Premiums, subject to the "*Grace Period on Late Payments*" provision;
- fraud or material misrepresentation made by or with the knowledge of the Primary Enrollee or the Enrollee applying for this coverage or filing a claim for Benefits;
- the Primary Enrollee changing to a new policy through the Exchange; or
- We cease to renew all Policies issued on this form to residents of the state where You live.

If Your coverage is terminated, We will send at least 30 days' advance written notice to You at the last address shown in Our records. We will inform You of the reasons(s) why coverage is terminated and the date that Your coverage will end. We will not pay for services received after the date coverage

ends. However, We will pay for the completion of Single Procedures started while You were eligible if they are completed within 31 days of the date coverage ended.

If termination is due to loss of eligibility through the 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.

Reinstatement

If this Policy is terminated, You may re-enroll in the plan at the next Open Enrollment Period. Any Deductible, Maximum, Out-of-Pocket Maximum and/or Waiting Period applicable to Your Benefits will start over. However, this Policy will be reinstated prior to Open Enrollment with no break in coverage as long as You pay any past due Premium within 90 days of the past due date (see "*Grace Period on Late Payments")*. Once We receive Your past due Premium We will reinstate this Policy within 45 days. If You reinstate by paying past due Premium within the 90 days, a new application is not required. The reinstated Policy will have the same rights as before Your Policy lapsed, unless a change is made to this Policy in connection with the reinstatement. These changes, if any, will be sent to You for You to attach to this Policy.

OVERVIEW OF DENTAL BENEFITS

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

Benefits, Limitations and Exclusions

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

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

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

Enrollee Coinsurance

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

The amount of Your Enrollee Coinsurance will depend on the type of service and the Provider furnishing the service (see section titled "*Selecting Your Provider*"). Providers are required to collect Enrollee Coinsurance for covered services. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to You, We will be obligated to provide as Benefits only the applicable

percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

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

Pre-Treatment Estimates

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

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

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

SELECTING YOUR PROVIDER

Free Choice of Provider

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

Locating a PPO Provider

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

Choosing a PPO Provider

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

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

Choosing a Premier Provider

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

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

Choosing a Non-Delta Dental Provider

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

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

Additional Obligations of PPO and Premier Providers

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

How to Submit a Claim

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

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

Delta Dental Insurance Company
P.O. Box 2105
Mechanicsburg, PA 17055-2105

Payment Guidelines

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

If You or Your Provider file a claim for services more than 12 months after the date You received the services, payment may be denied. If the services were received from a Non-Delta Dental Provider, You are still responsible for the full cost. If the payment is denied because Your PPO or Premier Provider failed to submit the claim on time, You may not be responsible for that payment. However, if You did not tell Your PPO or Premier Provider that You were covered under a Delta Dental Policy at the time You received the service, You may be responsible for the cost of that service.

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

Provider Relationships

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

GRIEVANCES AND APPEALS

Informal Internal Review

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

You may also designate an outside independent representative to assist You in following the grievance procedure.

Grievances regarding eligibility, the denial of dental services or claims, the policies, procedures, operations of Delta Dental or the quality of dental services performed by the Provider may be directed to Us via Our website at deltadentalins.com. You may also write to Us or call Us toll-free at 888-857-0314.

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

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

Send Your grievance to Us at the address shown below:

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

We will send You a written acknowledgment within five (5) days upon receipt of Your grievance. We will make a full and fair review within 14 business days after We receive the grievance. We may ask for more documents if needed. We will send You a decision within 14 business days. If the grievance is an appeal from a determination regarding urgent or emergency care, We will conclude the appeal within 24 hours of receiving notification of appeal from You or Your representative. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Policy, We will consult with a dentist who has appropriate training and experience. The review will be conducted for Us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

Formal Internal Review

If You believe You need further review of Your claim, You may file an appeal by requesting from Us a second level of review.

Our formal review appeals process provides You with the opportunity to pursue Your appeal before a reviewer or panel of Providers We select. We will acknowledge receipt of Your request to pursue a formal review appeal in writing within 10 business days of receipt. After We receive all the necessary documentation from You and Your Provider, Our formal internal appeal process will be conducted as soon as possible.

If the formal internal appeal is from a decision regarding urgent or emergency care, We will conclude the appeal within 24 hours from the time You or Your Provider provide Us notification of the appeal. All other appeals under this process will be concluded within 30 business days, unless You request an extension of time.

If We deny Your formal internal appeal, We will provide You or Your representative with a written explanation of the denial and written notification of Your right to proceed to an external appeal. This denial will be accompanied by all necessary forms for You to initiate the external appeal.

You also have the option to contact the District of Columbia Department of Insurance, Securities and Banking to request an investigation or file a complaint with the Department at any time during the internal claims and appeal process. You may contact the Department's Consumer Services Division at disb.complaints@dc.gov or call (202) 727-8000.

Formal External Review

Should You remain dissatisfied with the resolution of Your grievance, You have the right to contact the Commissioner of Insurance in pursuit of a formal external appeal. Within 30 business days from receipt of the written decision of the formal internal appeal panel, You or Your representative may initiate an external appeal by filing an external appeal with the Commissioner of Insurance. Your request must be accompanied by a signed form allowing Us to release medical records that are pertinent to the appeal.

Upon receipt of the request for an external appeal, together with the executed release form, the Commissioner will determine whether:

- You were or are a member of the benefit plan;
- The service which is the subject of the appeal reasonably appears to be a service covered under the benefit plan;
- You or Your representative have fully complied with the state laws regarding informal and formal internal appeals; and
- You or Your representative have provided all information required by the independent review organization and the Commissioner to make the preliminary determination, including the appeal form, and a copy of any information provided by Us regarding Our decision to deny, reduce or terminate a covered service, and the release form.

Upon completion of the preliminary review, the Commissioner will notify You or Your representative and Us as to whether the appeal has been accepted for processing. If the appeal is accepted by the Commissioner, the Commissioner will assign the appeal to an independent review organization ("IRO") for full review. If the appeal is not accepted by the Commissioner, the Commissioner will provide a statement of the reasons for the non-acceptance to You or Your representative and to us.

Upon acceptance of the appeal for processing, the IRO will conduct a full review to determine whether, as a result of Our decision, You were deprived of any service covered by this Policy.

We will provide all documentation to the IRO within 5 days of receipt of the notice of approval of the appeal by the Commissioner, or within 24 hours of receipt of the notice of approval of the grievance, for an expedited review.

The full review of an appeal will be initially conducted by at least 2 licensed Providers. In reaching its determination, the IRO will take into consideration all pertinent medical records, consulting Provider reports, and other documents submitted by You and Us, and any applicable generally accepted dental practice guidelines developed by the federal government, nation or professional dental societies, boards and associations, any applicable clinical protocols or practice guidelines developed by Us, and may consult with other professionals as appropriate and necessary.

You or Your representative may request to appear in person before the independent review organization. The organization will conduct a hearing as soon as possible after receiving a request from You or Your representative to appear before the IRO. The IRO will notify You or Your representative and Us, either orally or in writing, of the hearing date and location. At the hearing, You will be permitted to present Your case, submit any supporting material, ask questions of any representative of the IRO, and to be assisted or represented by a person of Your choice.

The IRO will complete its review and issues its recommended decision as soon as possible, within 30 business days or 72 hours in the case of an expedited appeal, from the time the Commissioner assigns the appeal to the organization.

If the IRO determines You were deprived of medically necessary covered services, the IRO will recommend to the Commissioner the appropriate covered services that You should receive. The Commissioner will forward copies of the recommendation to You or Your representative and us.

The decision of the IRO will be non-binding, and will not affect any other legal cause of action.

If You are dissatisfied with the resolution reached through Our internal grievance process regarding medical necessity, You may contact the Director, Office of Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases:

District of Columbia Department of Health Care Finance
Office of the Health Care Ombudsman and Bill of Rights
One Judiciary Square
441 4th Street, N.W., 250 North
Washington, DC 20001
Phone: 1 (877) 685-6391, (202) 724-7491
Fax: (202) 442-6724
Email: healthcareombudsman@dc.gov

If You are dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, You may contact the Commissioner at the following:

For Non-Medical Necessity cases:

Commissioner
Department of Insurance, Securities and Banking
1050 First Street, N.E., Suite 801
Washington, DC 20002
Phone: (202) 727-8000
Fax: (202) 354-1085
Email: disb@dc.gov

PREMIUM PAYMENT RESPONSIBILITIES

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

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

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

Rate Guarantee

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

Changing Payment Options

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

Grace Period on Late Payments

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

- If Your Premium payment is not received by the first of the month, a grace period of three (3) months will be granted. During the grace period, this Policy will continue in force. However, Your coverage for the second and third months of the grace period will be suspended and claims incurred during the second and third months of the grace period will not be paid unless all Premiums due are paid prior to the expiration of the grace period. If Premiums are received during the grace period, then 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 Policy will continue in force. Coverage will terminate at the end of the grace period unless We receive Your Premium before the end of this 31 days.

GENERAL PROVISIONS

Entire Contract; Changes

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

Severability

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

Incontestability

After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for this Policy will be used to void this Policy or to deny a claim for loss incurred or disability commencing after the expiration of such 3-year period.

No claim for loss incurred or disability commencing after three (3) years from the date of issue of this Policy will be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed prior to the Effective Date of this Policy.

Physical Examination and Autopsy

Before approving a claim, We will be entitled to receive, to such extent as may be lawful, information and records relating to the treatment provided to You as may be required to administer the claim. We, at Our own expense, will have the right and opportunity to examine the insured when and as often as it may reasonably require during the pendency of a claim, and to make an autopsy in case of death where it is not forbidden by law. Examination may be required by a dental consultant retained by Us in or near Your community or residence. We will in every case hold such information and records confidential.

Written Notice of Claim/Proof of Loss

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

All written proof of loss must be given to Us within 12 months of the termination of this Policy.

Send Your Notice of Claim/Proof of Loss to Us at the address shown below:

Delta Dental Insurance Company
P.O. Box 2105
Mechanicsburg, PA 17055-2105

Claim Form

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

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

Time of Payment

Claims payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be processed immediately after written proof of loss is received in the form required by the terms of this Policy. We will notify You and Your Provider of any additional information needed to process the claim.

To Whom Benefits Are Paid

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

Misstatements on Application; Effect

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

Legal Actions

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

Conformity with Applicable Laws

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

Holding Company

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

Third Party Administrator ("TPA")

We may use the services of a TPA, duly registered under applicable state law, to provide services under this Policy. Any TPA providing such services or receiving such information 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 (Policyholder or Us) will be liable to the other or be deemed to be in breach of this Policy for any failure or delay in performance arising out of causes beyond its reasonable control. Such causes are strictly limited to include acts of God or of a public enemy, explosion, fires or unusually severe weather. Dates and times of performance will be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay.

Non-Discrimination 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 reasonable modifications, appropriate auxiliary aids and services, for language assistance services, please call 866-530-9675 (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.

Delta Dental Insurance Company
Appeals and Grievances Dept.
P.O. Box 1860
Alpharetta, GA 30023-1860
888-857-0314
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
1-800-368-1019, 800-537-7697 (TDD)

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

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

Residents of the District of Columbia should know that licensed insurers or health maintenance organizations who sell health benefit plans, disability income insurance, long-term care insurance, life insurance, and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association").

The purpose of the Guaranty Association is to provide statutorily-determined benefits associated with covered policies and contracts in the unlikely event that a member insurer is unable to meet its financial obligations and is found by a court of law to be insolvent. When a member insurer is found by a court to be insolvent, the Guaranty Association will assess the other member insurers to satisfy the benefits associated with any outstanding covered claims of persons residing in the District of Columbia. However, the protection provided through the Guaranty Association is subjected to certain statutory limits explained under "Coverage Limitations" section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep the coverage in-force, with no change in contractual rights or benefits.

Coverage

The Guaranty Association, established pursuant to the Life and Health Guaranty Association Act of 1992 ("Act"), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code § 31-5401 *et seq.*), provides insolvency protection for certain types of insurance policies and contracts.

The insolvency protections provided by the Guaranty Association is generally conditioned on a person being 1) a resident of the District of Columbia and 2) either the individual insured or owner under a health benefit plan, disability income insurance, long-term care insurance, life insurance, or annuity contract issued by a member insurer or the individual insured under a group policy insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of District insureds are also covered under the Act, even if they reside in another state.

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- With respect to any one life, regardless of the number of policies, contracts, or certificates:
  - $300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 for long-term care insurance benefits;
  - $300,000 for disability income insurance benefits;
  - $500,000 for health benefit plans;
  - $100,000 for coverage not defined as disability income insurance; health benefit plans; or long term care insurance including any net cash surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than $300,000 in benefits with respect to any one life (except in the event of health benefit plans in which the Guaranty Association is liable for no more than $500,000).

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner, regardless of the number of policies owned.

Exclusions Examples

Policy or contract holders are not protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insureds that live outside of that state);
- Their insurer was not authorized to do business in the District of Columbia at the time the policy or contract was issued; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a risk retention group.

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits, or fees for services in connection with a policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contacts.

Consumer Protection

To learn more about the above referenced protections, please visit either:

District of Columbia **Life and Health Insurance** **Guaranty Association** **www.dclifega.org** **410-248-0407**	**District of Columbia** **Department of Insurance, Securities** **and Banking** **dc.disb.gov** **202-727-8000**

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and the amounts of coverage provided under the Act. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on the insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association would cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any rights established in any policy or contract or under the Act.

POLICY INFORMATION

Policyholder:

Effective Date:

Policy Year:

Policy ID Number:

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

Monthly Premium:

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

Deductibles & Maximums		
	Adult Benefits (age 19 and older)	**Pediatric Benefits (under age 19)**
Annual Deductible	The annual Deductible is waived for Diagnostic and Preventive Services.	
Enrollee	$50 each Calendar Year	$85 each Calendar Year
Family (three or more Enrollees)	$150 each Calendar Year	No family Deductible
Annual Maximum		
Enrollee	$1,000 each Calendar Year	No annual Maximum
Out-of-Pocket Maximum*		
Pediatric Enrollee	$450 each Calendar Year for only one covered Pediatric Enrollee	
Multiple Pediatric Enrollees	$900 each Calendar Year for two or more covered Pediatric Enrollees	

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

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

Policy Benefit Levels & Enrollee Coinsurances				
	Adult Benefits (age 19 and older)		**Pediatric Benefits (under age 19)**	
Dental Service Category	**Delta Dental PPO[1]**		**Delta Dental PPO[1]**	
	Delta Dental[2]	Enrollee[2]	Delta Dental[2]	Enrollee[2]
Diagnostic and Preventive Services	100%	0%	100%	0%
Basic Services	80%	20%	80%	20%
Major Services	50%	50%	50%	50%
Medically Necessary Orthodontic Services (requires prior authorization)	Not a covered Benefit	Not a covered Benefit	50%	50%
Waiting Periods	Major Services are limited to Adult Enrollees who have been enrolled under this Policy for 12 consecutive months.[3]		No Waiting Periods	

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

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

[3] Waiting Periods are calculated for each Adult Enrollee from the effective date of coverage reported by the Exchange for said Adult Enrollee. Prior coverage for Adult Enrollees under any Delta Dental Exchange plan that included an adult Waiting Period will be credited towards the adult Waiting Period under this dental plan. In order for prior coverage to be credited, such prior coverage must occur immediately preceding the election of this plan.

Attachment B
Services, Limitations and Exclusions

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

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

- **Diagnostic and Preventive Services**

(1)	Diagnostic:	procedures to aid the Provider in determining required dental treatment.
(2)	Preventive:	cleanings, including scaling in presence of generalized moderate or severe gingival inflammation - full mouth (periodontal maintenance is considered to be a basic service for payment purposes), topical application of fluoride solutions.
(3)	Specialist Consultations:	opinion or advice requested by a general dentist.

- **Basic Services**

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

- **Major Services**

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

- **Note on additional Benefits during pregnancy**

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

Limitations for Adult Benefits (Age 19 and Older)

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

Examples of Optional Services:

a) a composite restoration instead of an amalgam restoration on posterior teeth;

b) a crown where a filling would restore the tooth;

c) an inlay/onlay instead of an amalgam restoration; or

d) porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown).

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

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

(3) We will pay for oral examinations (except after hours exams and exams for observation) no more than twice in a Calendar Year.

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

(5) A caries risk assessment is allowed once in 12 months.

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

(7) Application of caries arresting medicament is limited to twice per tooth per Calendar Year.

(8) Topical application of fluoride solutions is limited to twice within a 12-month period.

(9) Image limitations:

a) We will limit the total reimbursable amount to the Provider's Accepted Fee for a comprehensive series of radiographic images when the fees for any combination of intraoral images in a single treatment series meet or exceed the Accepted Fee for a comprehensive intraoral series.

b) Benefits are limited to either one (1) comprehensive intraoral series or one (1) panoramic image once every 60 months.

c) If a panoramic image is taken in conjunction with a comprehensive intraoral series, We will limit reimbursement to the Provider's Accepted Fee for the comprehensive intraoral series, and the fee for the panoramic image will be Your responsibility.

d) Panoramic images are not considered part of a comprehensive intraoral series.

e) Bitewing images are limited to one (1) time per Calendar Year for age 18 and over. Unless warranted by special circumstances, bitewings of any type are included in the fee for a comprehensive series when taken within 6 months of the comprehensive series.

f) Image capture procedures are not separately billable services.

(10) Cone beam image limitations:

a) Cone beam capture and interpretation is covered no more than once in a 12-month period.

b) Interpretation of a diagnostic image only is covered for cone beam services.

c) This service is covered no more than once in a 12-month period.

d) Cone beam interpretation is a covered Benefit when provided by a different Provider/Provider office than the Provider/Provider office who provided the cone beam capture services only.

e) Cone beams are considered to be a major Benefit for payment purposes.

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

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

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

(14) The removal of an indirect restoration is a part of a subsequent restorative procedure.

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

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

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

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

(19) Placement of interim direct restoration is included in the fee for all covered endodontic procedures when done on the same date by the same Provider/Provider office.

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

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

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

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

(24) Periodontal limitations:

a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service. See note on additional Benefits during pregnancy.

b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same Provider/Provider office.

c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.

d) Guided tissue regeneration and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.

e) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.

f) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.

g) When implant procedures are a covered Benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surface, without flap entry and closure is covered as a basic Benefit and are limited to once in a 24-month period.

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

(26) The Socket Shield technique, partial extraction of the root of a tooth at the time of implant placement, is only a Benefit when performed with simultaneous implant placement.

(27) When performed in conjunction with the removal of an impacted tooth, complete bony with unusual surgical complications, nerve dissection is included with the extraction procedure. Otherwise, nerve dissection is not a Benefit.

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

(29) Crowns and inlays/onlays are covered not more often than once in any 60-month period except when We determine the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

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

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

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

(33) When allowed within six (6) months of a restoration, the Benefit for a crown, inlay/onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

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

(35) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Delta Dental plan will be replaced only after 60 months have passed, except when We determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental plan will be made if We determine it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Our payment for implant removal is limited to one (1) for each implant in 60 months whether provided under Delta Dental or any other dental care plan. Implant/abutment supported removable dentures and fixed dentures will receive a Benefit allowance for the corresponding conventional removable appliances. You are responsible for the difference in the fee for an implant/abutment supported denture and the fee for a conventional prosthodontic appliance.

(36) Fees for replacement of an implant screw are included in the service to insert an implant or abutment supported prosthesis (crown, bridge or denture) when provided within 6 months of the insertion of the prosthesis. Accessing and retorquing a loose implant screw is part of the service to replace an implant screw.

(37) Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments, are covered once in 36 months.

(38) Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments, is included in the fee for the denture service, when performed within 12 months of the insertion of the denture.

(39) Debridement of a peri-implant defect or defects surrounding a single implant (with or without osseous contouring), and surface cleaning of the exposed implant surfaces, including flap entry and closure, are covered once in 36 months.

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

(41) Recementation of crowns, inlays/onlays, indirectly fabricated or prefabricated post and core, or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.

(42) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time You were covered under a Delta Dental plan.

(43) The fee for accessing and retorquing a loose implant screw is included in the fee for the delivery of the implant supported prosthesis when performed within 6 months of the placement of the prosthesis.

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

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

a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.

b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period.

c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline or rebase service.

d) Recementation of fixed partial dentures is limited to once in a lifetime.

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

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

Exclusions for Adult Benefits (Age 19 and Older)

We do not pay Benefits for:

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

(2) cosmetic surgery or procedures for purely cosmetic reasons.

(3) administration of dermal fillers is not a Benefit of the plan.

(4) administration of neuromodulators is not a Benefit of the plan.

(5) maxillofacial prosthetics.

(6) provisional and/or temporary restorations.

(7) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.

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

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

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

(11) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.

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

(13) interim implants.

(14) indirectly fabricated resin-based inlays/onlays.

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

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

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

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

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

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

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

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

(23) the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while You are covered under the Policy or was covered under any dental care plan with Us. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

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

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

(26) endodontic endosseous implants.

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

(28) missed and/or cancelled appointments.

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

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

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

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

(33) extraoral – 2D projection radiographic image and extraoral posterior dental radiographic image.

(34) diabetes testing.

(35) corticotomy (specialized oral surgery procedure associated with orthodontics).

(36) antigen or antibody testing.

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

(38) services and supplies for sleep apnea.

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

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

- **Diagnostic and Preventive Services**

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

- **Basic Services**

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

- **Major Services**

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

- **Note on additional Benefits during pregnancy**

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

Limitations for Pediatric Benefits (Under Age 19)

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

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

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

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

(4) Exam and cleaning limitations:

a) We will pay for oral examinations (except after hours exams and exams for observation) and routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) no more than twice in a Calendar Year. Periodontal maintenance are limited to four (4) times in a 12-month period. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) not to exceed four (4) procedures in a 12-month period. See note on additional Benefits during pregnancy.

b) A full mouth debridement is allowed once in a lifetime, when You have no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three years, and counts toward the cleaning frequency in the year provided.

c) Note that periodontal maintenance, Procedure Codes that include periodontal maintenance, and full mouth debridement are covered as a basic Benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a diagnostic and preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.

d) Caries risk assessments are allowed once in 12 months.

e) Full mouth debridement is not allowed when performed by the same Provider/Provider office on the same day as evaluation procedures.

(5) Application of caries arresting medicament is limited to twice per tooth per Calendar Year.

(6) Image limitations:

a) We will limit the total reimbursable amount to the Provider's Accepted Fee for a comprehensive series of radiographic images when the fees for any combination of intraoral images in a single treatment series meet or exceed the Accepted Fee for a comprehensive intraoral series.

b) Benefits are limited to once every sixty months for comprehensive intraoral series and panoramic image.

c) If a panoramic image is taken in conjunction with a comprehensive intraoral series, We will limit reimbursement to the Provider's Accepted Fee for the comprehensive intraoral series, and the fee for the panoramic image will be Your responsibility.

d) Panoramic images are not considered part of a comprehensive intraoral series.

e) Bitewing images are limited to once every six (6) months. Unless warranted by special circumstances, bitewings of any type are included in the fee for a comprehensive series when taken within 6 months of the comprehensive series.

f) Image capture procedures are not separately billable services.

(7) Cone beam image limitations:

a) Cone beam capture and interpretation is covered no more than once in a 12-month period.

b) Interpretation of a diagnostic image only is covered for cone beam services.

c) This service is covered no more than once in a 12-month period.

d) Cone beam interpretation is a covered Benefit when provided by a different Provider/Provider office than the Provider/Provider office who provided the cone beam capture only services.

e) Cone beams are considered to be a major Benefit for payment purposes.

(8) The fee for pulp vitality tests are included in the fee for any definitive treatment performed on the same date.

(9) Topical application of fluoride solutions is limited to twice within a 12-month period.

(10) A distal shoe space maintainer - fixed - unilateral is limited to children 8 and younger and is limited to once per quadrant per lifetime. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe. The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(11) Sealants are limited as follows:

a) once in 36 months to permanent molars if they are without caries (decay) or restorations on the occlusal surface.

b) repair or replacement of a sealant on any tooth within 24 months of its application is included in the fee for the original placement.

(12) Preventive resin restorations in a moderate to high risk caries risk patient - permanent tooth are limited to once per tooth in 36 months.

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

(14) We will not cover replacement of an amalgam or resin-based composite restorations (fillings) within 24 months of treatment if the service is provided by the same Provider/Provider office. Prefabricated crowns are limited to once per Enrollee per tooth in any 60-month period. Replacement restorations within 24 months are included in the fee for the original restoration.

(15) Protective restorations (sedative fillings) are allowed when definitive treatment is not performed on the same date of service. The fee for protective restorations is included in the fee for any definitive treatment performed on the same date.

(16) The removal of an indirect restoration is a part of a subsequent restorative procedure.

(17) Prefabricated stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth through age 14. Replacement restorations within 24 months are included in the fee for the original restoration.

(18) Therapeutic pulpotomy is limited to baby (deciduous) teeth only; an allowance for an emergency palliative treatment is made when performed on permanent teeth.

(19) Pulpal therapy (resorbable filling) is limited to once in a lifetime and to primary incisor teeth for Enrollees up to age 6 and for primary molars and cuspids up to age 11. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(20) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation.

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

(22) Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.

(23) Palliative treatment is covered per visit, not per tooth, and the fee for palliative treatment provided in conjunction with any procedures other than images or select diagnostic procedures is considered included in the fee for the definitive treatment.

(24) Periodontal limitations:

a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service. See note on additional Benefits during pregnancy.

b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same Provider/Provider office.

c) Periodontal services, including graft procedures are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.

d) Bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.

e) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.

f) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.

g) When implant procedures are a covered Benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a basic Benefit and are limited to once in a 24-month period.

(25) The Socket Shield technique, partial extraction of the root of a tooth at the time of implant placement, is only a Benefit when done with simultaneous implant placement.

(26) When performed in conjunction with the removal of an impacted tooth, complete bony with unusual surgical complications, nerve dissection is included with the extraction procedure. Otherwise, nerve dissection is not a Benefit.

(27) Collection and application of autologous blood concentrate product are limited to once every 36 months.

(28) Crowns and inlays/onlays are covered not more often than once in any 60-month period except when We determine the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues. Services will only be allowed on teeth that are developmentally mature.

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

(30) Prefabricated post and core, in addition to crown is covered once per tooth every 60-month period.

(31) Resin infiltration of incipient smooth surface lesions is covered once in any 36-month period.

(32) When allowed within six (6) months of a restoration, the Benefit for a crown, inlay/onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(33) Prosthodontic appliances, implants and/or implant supported prosthetics (except for implant/abutment supported removable dentures) that were provided under any Delta Dental plan will be replaced only after 60 months have passed, except when We determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental plan will be made if We determine it is unsatisfactory and cannot be made satisfactory. Services will only be allowed on teeth that are developmentally mature. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Our payment for implant removal is limited to one (1) for each implant within a 60-month period whether provided under Delta Dental or any other dental care plan.

(34) Fees for replacement of an implant screw are included in the service to insert an implant or abutment supported prosthesis (crown, bridge or denture) when provided within 6 months of the insertion of the prosthesis. Accessing and retorquing a loose implant screw is part of the service to replace an implant screw.

(35) Debridement and/or osseous contouring of a peri-implant defect, or defects surrounding a single implant, and includes surface cleaning of the exposed implant surface, including flap entry and closure is allowed once every 60-month period.

(36) Implant maintenance procedures, when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments, is included in the fee for the denture service, when performed within 12 months of the insertion of the denture.

(37) An implant is a covered procedure of the plan only if determined to be a dental necessity. If an arch can be restored with a standard prosthesis or restoration, no Benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate Benefit provision of the plan.

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

(39) Recementation of crowns, inlays/onlays or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement.

(40) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time You were covered under a Delta Dental plan.

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

a) Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.

b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, relining is limited to one (1) per arch in a 36-month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, relining is limited to one (1) per arch in a 36-month period.

c) Tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline or rebase service.

(42) Occlusal guards are covered by report for Enrollees age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period. We will not cover the repair or replacement of any appliances for night guard/occlusal guard. Adjustment of an occlusal guard is allowed once in 12-months following six months from initial placement.

(43) Limitations on Orthodontic Services:

a) Services are limited to medically necessary orthodontics when provided by a Provider. 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 the plan.

b) 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.

c) The automatic qualifying conditions are:

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

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

iii) a crossbite of individual anterior teeth causing destruction of soft tissue.

iv) severe traumatic deviation.

d) The following documentation must be submitted with the request for prior authorization of services by the Provider:

i) ADA 2006 or newer claim form with service code(s) requested;

ii) diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;

iii) cephalometric radiographic image or panoramic radiographic image;

iv) HLD score sheet completed and signed by the orthodontist; and

v) treatment plan.

e) 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.

f) Limited orthodontic treatment (any dentition) and comprehensive orthodontic treatment (any dentition) are included with comprehensive orthodontic treatment with orthognathic surgery.

g) Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.

h) Orthodontic procedures are Benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Enrollees under the age of 19 and must be prior authorized.

i) 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.

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

k) 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. You are responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist's charge for the specialized orthodontic appliance or procedure.

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

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

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

- for 60 days if You are making monthly payments to the Provider; or
- until the latter of 60 days after the date the coverage terminates or the end of the quarter in progress, if You are making quarterly payment to the Provider.

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

n) 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.

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

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

Exclusions for Pediatric Benefits (Under Age 19)

We do not pay Benefits for:

(1) services that are not Essential Health Benefits.

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

(3) cosmetic surgery or procedures for purely cosmetic reasons.

(4) administration of dermal fillers is not a Benefit of the plan.

(5) administration of neuromodulators is not a Benefit of the plan.

(6) maxillofacial prosthetics.

(7) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.

(8) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.

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

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

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

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

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

(14) laboratory processed crowns for teeth that are not developmentally mature.

(15) endodontic endosseous implants.

(16) indirectly fabricated resin-based inlays/onlays.

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

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

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

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

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

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

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

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

(25) the initial placement of any prosthodontic appliance or implant, unless such placement is needed to replace one or more natural, permanent teeth extracted while You are covered under the Policy or was covered under any dental care plan with Us. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

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

(27) services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary orthodontics provided a prior authorization is obtained.

(28) missed and/or cancelled appointments.

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

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

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

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

(33) extraoral – 2D projection radiographic image and extraoral posterior dental radiographic image.

(34) cone beam image capture only.

(35) diabetes testing.

(36) corticotomy (specialized oral surgery procedure associated with orthodontics).

(37) antigen or antibody testing.

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

(39) services and supplies for sleep apnea.

DELTA DENTAL®

deltadentalins.com

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។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ 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 אַט די דאָזיקע נומער: 1-866-530-9675 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bííníghah? Doo bííníghahgóó éí nich'į' yídóołtahígíí nihee hólǫ. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaago ałdó' nich'į' ádoolnííłgo bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojį' béésh holdííłnih 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).

DELTA DENTAL®

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

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).