Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: DeltaCare® USA Family Dental HMO for Small Businesses **Name of Product:** DeltaCare USA
Type of Product Line: DHMO **Plan Phone #:** 888-282-8528
Effective Date: 01/01/27 **Plan Website:** deltadentalins.com/hcx

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE deltadentalins.com/hcx OR CALL 888-282-8528

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	None	Not Applicable
Orthodontia	None	Not Applicable

- **There is no deductible.**
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your plan to provide dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	None	Not Applicable
Lifetime or Annual Maximum for Orthodontia	None	Not Applicable

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

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **Your dental benefit package has no waiting periods.**

Part V: WHAT YOU WILL PAY

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

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Preventive & Diagnostic	$0	Not Covered	• Up to Age 19: 1 per Contract Dentist • Refer to the Disclosure Form for the full limitation and exclusion

Bitewing X-ray	Preventive & Diagnostic	$0	Not Covered	• Up to Age 19: 1 per date of service • Refer to the Disclosure Form for the full limitation and exclusion
Cleaning	Preventive & Diagnostic	$0	Not Covered	• 1 per 6 months • Refer to the Disclosure Form for the full limitation and exclusion

Common Dental Procedures	**Category**	**In-Network**	**Out-of-Network**	**Benefit Limitations and Exclusions**
Filling	Basic	$30	Not Covered	• Up to Age 19: 1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth • Refer to the Disclosure Form for the full limitation and exclusion
Extraction, Erupted Tooth or Exposed Root	Basic	$65	Not Covered	• No limitations or exclusions • Refer to the Disclosure Form for the full limitation and exclusion
Root Canal	Basic	$300	Not Covered	• No limitations or exclusions • Refer to the Disclosure Form for the full limitation and exclusion
Scaling and Root Planing	Basic	$55	Not Covered	• Up to Age 19: 1 per quadrant per 25 months; age 13+ • Age 19 and Older: 4 quadrants per 12 consecutive months • Refer to the Disclosure Form for the full limitation and exclusion
Ceramic Crown	Major	$300	Not Covered	• Up to Age 19: 1 per 60 months, permanent teeth; age 13 through 18 • Age 19 and Older: 1 per 60 months • Refer to the Disclosure Form for the full limitation and exclusion
Removable Partial Denture	Major	$335 - $375	Not Covered	• 1 per 60 months • Refer to the Disclosure Form for the full limitation and exclusion

Extraction, Erupted Tooth with Bone Removal	Basic	$115 - $120	Not Covered	• No limitations or exclusions • Refer to the Disclosure Form for the full limitation and exclusion
Orthodontia	Orthodontia	$350	Not Covered	• Refer to the Disclosure Form for the full limitation and exclusion • Medically Necessary for Enrollees up to age 19.

Part VI: COVERAGE EXAMPLES

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

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

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Total Cost of Care	In-network: $400 Out-of-network: $550	Total Cost of Care	In-network: $150 Out-of-network: $200	Total Cost of Care	In-network: $1,300 Out-of-network: $1,750

Deductible	In-network: None Out-of-network: Not Covered	Deductible	In-network: None Out-of-network: Not Covered	Deductible	In-network: None Out-of-network: Not Covered
Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not Covered	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not Covered	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not Covered

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Patient Cost (copayment or coinsurance)	**In-network:** Up to Age 19: $0 Age 19 and Older: $0 **Out-of-network:** Not Covered	Patient Cost (copayment or coinsurance)	**In-network**: Up to Age 19: $30 Age: 19 and Older: $30 **Out-of-network:** Not Covered	Patient Cost (copayment or coinsurance)	**In-network:** Up to Age 19: $300 Age 19 and Older: $300 **Out-of-network:** Not Covered
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** Up to Age 19: $0 Age 19 and Older: $0 Out-of-network: Up to Age 19: $550 Age 19 and Older: $550	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** Up to Age 19: $30 Age 19 and Older: $30 Out-of-network: Up to Age 19: $200 Age 19 and Older: $200	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** Up to Age 19: $300 Age 19 and Older: $300 **Out-of-network:** Up to Age 19: $1,750 Age 19 and Older: $1,750

Summary of what is not covered or subject to a limitation:	• Oral Exam: Up to Age 19: 1 per Contract Dentist • X-ray: Up to Age 19: 1 series per 36 months per Contract Dentist; Age 19 and Older: 1 series per 25 months • Cleaning: Up to Age 19: 1 per 6 months; Age 19 and Older: 2 per 12 months	Summary of what is not covered or subject to a limitation:	• Up to Age 19: 1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth	Summary of what is not covered or subject to a limitation:	• Up to Age 19: 1 per 60 months, permanent teeth; age 13 through 18 • Age 19 and Older: 1 per 60 months

DeltaCare® USA



DeltaCare® USA
Family Dental HMO for Small Businesses

Group Name

Group No.

Effective Date

Combined Evidence of Coverage and Disclosure Form **("EOC")**

Provided by:

Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105
888-282-8528 (TTY: 711)
deltadentalins.com

Administered by:

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023-1803
888-282-8528 (TTY: 711)
deltadentalins.com

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

NOTICE: THIS EOC CONSTITUTES ONLY A SUMMARY OF YOUR GROUP DENTAL PLAN AND ITS ACCURACY SHOULD BE VERIFIED BEFORE RECEIVING TREATMENT. AS REQUIRED BY THE CALIFORNIA HEALTH AND SAFETY CODE, THIS IS TO ADVISE YOU THAT THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. THIS INFORMATION IS NOT A GUARANTEE OF COVERED BENEFITS, SERVICES OR PAYMENTS.

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

TABLE OF CONTENTS

INTRODUCTION 1

DEFINITIONS 2

ELIGIBILITY AND ENROLLMENT 5

CANCELLATION OF COVERAGE BY YOU 5

CANCELLATION, RESCISSION OR NON-RENEWAL OF COVERAGE BY US 6

OVERVIEW OF DENTAL BENEFITS 9

HOW TO USE THE DELTACARE USA PLAN/CHOICE OF CONTRACT DENTIST 11

ENROLLEE CLAIMS COMPLAINT PROCEDURE 15

GENERAL PROVISIONS 16

ATTACHMENTS:

SCHEDULE A – DESCRIPTION OF BENEFITS AND COPAYMENTS

SCHEDULE B – LIMITATIONS AND EXCLUSIONS OF BENEFITS

SCHEDULE C – INFORMATION CONCERNING BENEFITS UNDER THE DELTACARE USA PLAN

INTRODUCTION

We are pleased to welcome You to the DeltaCare USA dental plan ("Plan"). Your employer ("Contractholder") has chosen to participate in the Exchange and You have selected Delta Dental of California ("Delta Dental" or "Issuer") to meet Your dental needs. This Plan is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company.

Our goal is to provide You with the highest quality dental care and to help You maintain good dental health. We encourage You not to wait until You have a problem to visit the Dentist but to visit one on a regular basis.

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

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

Using This EOC

This EOC, including Attachments, discloses the terms and conditions of Your coverage and is designed to help You make the most of Your dental plan. It will help You understand how this Plan works and how to obtain dental care.

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

Request Confidential Communications

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

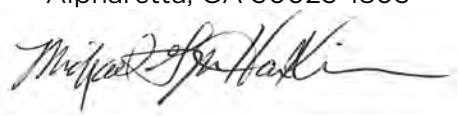
This EOC is *not* a Summary Plan Description to meet the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA").

Identification Number - You should provide Your identification ("ID") number to Your DeltaCare USA Dentist whenever You receive dental services. ID cards are not required but may be obtained by visiting Our website at **deltadentalins.com**.

Contract – The Benefit explanations contained in this EOC are subject to all provisions of the Contract on file with Your employer and do not modify the terms and conditions of the Contract in any way. Any direct conflict between the Contract and this EOC will be resolved according to the terms which are most favorable to You. A copy of the Contract will be furnished to You upon request.

Contact Us – For more information, visit Our website at **deltadentalins.com** or call Our Customer Care at **888-282-8528**. A representative can help with: answering questions about Your plan, explaining Benefits, locating a Contract Dentist, language assistance services and reasonable modifications to communicate effectively with Us and filing a grievance. If You prefer to write to Us, please mail it to:

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



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

DEFINITIONS

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

Administrator: Delta Dental Insurance Company or other entity designated by Delta Dental operating as an Administrator in the state of California. Certain functions described throughout this EOC may be performed by the Administrator as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023-1803. The Administrator will answer calls directed to **888-282-8528**. May also be referred to as the "Third Party Administrator" or "TPA."

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

Authorization: the process by which We determine if a procedure or treatment is a referable Benefit to Enrollees covered under this Plan.

Benefits: covered dental services provided to Enrollees under the terms of the Contract and as described in this EOC.

Billed for the Charge: a bill that provides, at a minimum, an accurate itemization of the Premium amounts due, the due dates(s), and the period of time covered by the Premium(s).

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

Contract: the agreement between Delta Dental and the Contractholder, including any Attachments, pursuant to which Delta Dental has issued this EOC.

Contract Dentist: a DeltaCare USA Dentist who provides services in general dentistry and who has agreed to provide Benefits to Enrollees covered under this Plan. Referrals for Specialist Services must be obtained from Your Contract Dentist.

Contract Orthodontist: a DeltaCare USA Dentist who specializes in orthodontics and who has agreed to provide Benefits to Enrollees covered under this Plan which covers medically necessary orthodontics. Services obtained from a Contract Orthodontist must be referred by Your Contract Dentist.

Contract Specialist: a DeltaCare USA Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees covered under this Plan. Services obtained from a Contract Specialist must be referred by Your Contract Dentist.

Contract Term: the period during which the Contract is in effect.

Contract Year: the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

Contractholder: an employer that is deemed eligible by the Exchange and has contracted for Benefits under this Plan through the Exchange.

Copayment: the amount listed in *Schedule A* attached to this EOC that is charged to You by a Contract Dentist, Contract Orthodontist or Contract Specialist for Benefits provided to Enrollees covered under this Plan. Copayments must be paid at the time treatment is received.

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

Dentist: a duly licensed dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed. A dentist includes a dental partnership, dental professional corporation or dental clinic. Also referred to as a "Provider."

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

Effective Date: the original date the Contract starts.

Eligible Dependent: a person who is a dependent of an Eligible Employee. Eligible Dependents are eligible for either Pediatric Benefits or Adult Benefits as described in this EOC.

Eligible Employee: an individual employed by the Contractholder and eligible for Benefits. Eligible Employees are eligible for either Pediatric Benefits or Adult Benefits under this EOC.

Eligible Pediatric Individual: a person who is a dependent of an Eligible Employee and eligible for Pediatric Benefits as described in this EOC.

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

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

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

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

Enrollee's Effective Date: the date the Exchange reports coverage will begin for each Enrollee.

Essential Health Benefits ("Pediatric Benefits"): for the purposes of this EOC, Essential Health Benefits are certain pediatric oral services that are required to be included 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.

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

Health Insurance Marketplace ("the Exchange" or "the Marketplace"): the California Health Benefit Exchange also referred to as "Covered California™.

Member: same as Enrollee.

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

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

Open Enrollment Period: the period of the year that the employer has established when the Eligible Employee may change coverage selections for the next Contract Year.

Optional: any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure but is chosen by the Enrollee and is subject to the limitations and exclusions as described in the Schedules attached to this EOC.

Out-of-Network: treatment by a Dentist who has not signed an agreement with Us to provide Benefits to Enrollees covered under the terms of the Contract.

Out-of-Pocket Maximum ("OOPM"): the maximum amount that a Pediatric Enrollee must satisfy for Benefits during the Contract Year. Refer to *Schedule A* attached to this EOC for details.

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

Provider: same as a "Dentist."

Qualifying Status Change:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step-child or death of a child);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee moves);
- court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by Internal Revenue Code Section 125 or the Exchange.

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

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

Specialist Services: services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics (if medically necessary) or pediatric dentistry. Specialist Services must be authorized by Us.

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

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

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).

Treatment in Progress: any Single Procedure, as defined by the CDT Code that has been started while the Enrollee was eligible to receive Benefits and for which multiple appointments are necessary to complete the Single Procedure(s), whether or not the Enrollee continues to be eligible for Benefits under this Plan. Examples include: 1) teeth that have been prepared for crowns, 2) root canals where a working length has been established, 3) full or partial dentures for which an impression has been taken and 4) orthodontics when bands have been placed and tooth movement has begun.

Urgent Dental Services: medically necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

Waiting Period (if applicable): the amount of time an Enrollee must be enrolled under the Contract for specific services to be covered.

We, Us and Our: Delta Dental or our Administrator, as appropriate.

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

ELIGIBILITY AND ENROLLMENT

The Exchange is responsible for establishing eligibility and reporting enrollment to Us based on information from the employer. We process enrollment as reported by the Exchange.

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

Eligibility Requirements for Pediatric Benefits

Pediatric Enrollees eligible for Pediatric Benefits are:

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

Eligibility Requirements for Adult Benefits

Adult Enrollees eligible for Adult Benefits are:

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

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

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

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

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

Enrollment

You may be required to contribute towards the cost of coverage for Yourself, Dependent Enrollees and Pediatric Enrollees. The Exchange is responsible for establishing an Enrollee's Effective Date for enrollment.

Eligible Employees may enroll for coverage during the Open Enrollment Period or due to a Qualifying Status Change. Dependents on active military duty are not eligible.

CANCELLATION OF COVERAGE BY YOU

You have the right to terminate coverage under this Plan by contacting the Exchange. The effective date of a requested termination will be at least 14 days from the date of Your request for termination. We will notify the Contractholder of any requests for termination received from Primary Enrollees. 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.

You lose eligibility when the Primary Enrollee is no longer reported as eligible by the Exchange or as eligible under the terms of the Contract. If termination is due to loss of eligibility through the Exchange, termination is effective the last day of the month following the month of termination. If termination is due to age, termination is effective the last day of the Calendar Year the Enrollee loses eligibility.

CANCELLATION, RESCISSION OR NON-RENEWAL OF COVERAGE BY US

Cancellation of Enrollment Due to Non-Payment of Premium

Grace Period

We may cancel the Contract after giving written notice to the Contractholder if Premiums, or a portion of Premiums, are not paid by the due date after being Billed for the Charge. We will provide a Notice of Start of Grace Period to the Contractholder stating a payment delinquency has triggered a Grace Period of 30 days starting the day the Notice of Start of Grace Period is dated. The Contractholder will promptly send or make available a copy of this notice to You. Your coverage will continue in effect during the Grace Period.

You are financially responsible for any and all Premiums, any Copayments, coinsurance or deductible amounts, including those incurred for services received during the Grace Period.

A Notice of End of Coverage will be provided to the Contractholder for all cancellations after the date coverage has ended, but no later than five (5) calendar days after the date coverage has ended that includes the following statement: "To learn about new coverage or whether your coverage can be reinstated, contact Delta Dental of California at deltadentalins.com." The Contractholder will promptly send or make available a copy of this notice to You. If You lose coverage, You may be financially responsible for the payment of claims incurred.

Cancellation of Enrollment Other Than Non-Payment of Premium

For cancellation, rescission and non-renewal of coverage other than for non-payment of Premium, We will provide the Contractholder with a Notice of Cancellation, Rescission or Nonrenewal. The Contractholder will promptly send or make available a copy of this notice You. A Notice of End of Coverage will be provided to the Contractholder for all cancellations after the date coverage has ended, but no later than five (5) calendar days after the date coverage has ended that includes:

- The following statement: "To learn about new coverage or whether your coverage can be reinstated, contact Delta Dental of California at deltadentalins.com."
- Notice as to the availability of the right to request completion of covered services.

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

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

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

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

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

You may submit online at **deltadentalins.com**, call **888-282-8528** or write to:

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

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

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

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

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

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

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

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

Reinstatement of Coverage

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

Strike, Lay-off and Leave of Absence

Enrollees will not be covered for any dental services received while the Eligible Employee is on strike, lay-off or leave of absence, other than as required under the Family & Medical Leave Act of 1993 or other applicable state or federal law*.

Coverage will resume after the Eligible Employee returns to work provided the Contractholder submits a request to the Exchange that coverage be reactivated. Benefits for Enrollees will resume as follows:

- If coverage is reactivated in the same Contract Year, coverage will resume as if the Eligible Employee was never gone.
- If coverage is reactivated in a different Contract Year, any Out-of-Pocket Maximum applicable to Your Benefits will start over.
- If the Eligible Employee is rehired within the same Contract Year, coverage will resume as if the Eligible Employee was never gone.

*Coverage for Enrollees is not affected if the Eligible Employee takes a leave of absence allowed under the Family & Medical Leave Act of 1993 or other applicable state or federal law. If the Eligible Employee is currently paying any part of the Premium, they may choose to continue coverage. If the Eligible Employee does not continue coverage during the leave, they can resume coverage for Enrollees on their return to active work as if no interruption occurred.

Important: The Family & Medical Leave Act of 1993 does not apply to all companies, only those that meet certain size guidelines. Contact Your Human Resources Department for complete information.

Continued Coverage Under USERRA

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), if the Eligible Employee is covered by the Contract on the date their USERRA leave of absence begins, dental coverage for the Eligible Employee and any covered dependents may continue. Continuation of coverage under USERRA may not extend beyond the earlier of:

- 24 months, beginning on the date the leave of absence begins; or
- the date the Primary Enrollee fails to return to work within the time required by USERRA.

For USERRA leave that extends beyond 31 days, the Premium for continuation of coverage will be the same as for COBRA coverage.

Continuation of Coverage Under COBRA

COBRA (the "Consolidated Omnibus Budget Reconciliation Act of 1985") provides a way for the Eligible Employee who loses employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. Contact Your Human Resources Department for complete information.

We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

Continuation of Coverage Under Cal-COBRA

Cal-COBRA (the "California Continuation Benefits Replacement Act") provides a way for You and Your Dependent Enrollees who lose employer-sponsored group health coverage ("Qualified Beneficiary") to continue coverage for a period of time. We agree to provide the Benefits to Enrollees who elect continued coverage pursuant to this section provided:

- continuation of coverage is required to be offered under Cal-COBRA;
- Contractholder notifies Us in writing of any Employee who has a qualifying event within 30 days of the qualifying event;
- Contractholder notifies Us in writing of any Qualified Beneficiaries currently receiving continuation of coverage from a previous plan;
- Contractholder notifies Qualified Beneficiaries currently receiving continuation coverage under another plan, of the Qualified Beneficiary's ability to continue coverage under Our new group benefit plan for the balance of the period the Qualified Beneficiary is eligible for continuation coverage. This notice will be provided either 30 days prior to the termination or when all enrolled Employees are notified, whichever is later;
- Contractholder notifies the Qualified Beneficiary of the ability to elect coverage under the Contractholder's new dental plan, if Contractholder terminates Contract and replaces Us with another dental plan. Said notice will be provided the later of 30 days prior to termination of Our coverage or when the Enrollees are notified;
- Qualified Beneficiary requests the continuation of coverage within the time frame allowed;
- We receive the required Premium for the continued coverage; and
- the Contract stays in force.

We do not assume any of the obligations required by Cal-COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under Cal-COBRA.

OVERVIEW OF DENTAL BENEFITS

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

What is the DeltaCare USA Plan?

The DeltaCare USA Plan provides Pediatric Benefits and Adult Benefits through a convenient network of Contract Dentists using the DeltaCare USA Network within the Delta Dental Service Area in the state of California. The DeltaCare USA Network is comprised of established dental professionals who are screened to ensure that Our standards of quality, access and safety are maintained. When You visit Your assigned Contract Dentist, You pay only the applicable Copayment(s) for Benefits. There are no deductibles, lifetime maximums or claim forms.

Benefits, Limitations and Exclusions

The DeltaCare USA Plan provides the Benefits described in the Schedules attached to this EOC. Except for Emergency Dental Services, Urgent Dental Services and authorized Specialist Services, Benefits are only available in the state of California. Services are performed as deemed appropriate by Your assigned Contract Dentist.

Copayments and Other Charges

You are required to pay any Copayments listed in *Schedule A* attached to this EOC. Copayments are paid directly to the DeltaCare USA Dentist who provides treatment.

In the event that We fail to pay a DeltaCare USA Dentist, You will not be liable to that DeltaCare USA Dentist for any sums owed by Us. By statute, the DeltaCare USA Dentist agreement contains a provision prohibiting a DeltaCare USA Dentist from charging an Enrollee for any sums owed by Us. Except for Emergency Dental Services, Urgent Dental Services and authorized Specialist Services, if You receive treatment from an Out-of-Network Dentist and We fail to pay that Out-of-Network Dentist, You may be liable to that Out-of-Network Dentist for the cost of services received. For further clarification, refer to the "Emergency Dental Services," "Urgent Dental Services" and "Specialist Services" provisions in this EOC.

We recommend keeping a record of payment for Pediatric Benefits. However, You may request from Us anytime an up-to-date accrual balance toward Your OOPM. If You would like to request this accrual information, please call Us at **888-282-8528**. We will mail it to the address on file unless You elect to receive it electronically.

Non-Covered Services

IMPORTANT: If You opt to receive dental services that are not covered services under this Plan, a participating dental Provider may charge You their usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about dental coverage options, You may call Customer Care at **888-282-8528**. To fully understand Your coverage, You may wish to carefully review this EOC.

Coordination of Benefits

We coordinate the Benefits under this EOC with Your benefits covered under any other group or pre-paid plan or insurance policy designed to fully integrate with other plans. If this Plan is the "primary" plan, We will not reduce Benefits, but if this Plan is the "secondary" plan, We determine Benefits after those of the primary plan and will pay the lesser of the amount that We would pay in the absence of any other dental benefit coverage or the Enrollee's total out-of-pocket cost under the primary plan for Benefits covered under this EOC.

How do We determine which Plan is the "primary" plan?

(1) The plan covering the Enrollee as an employee is primary over a plan covering the Enrollee as a dependent.

(2) The plan covering the Enrollee as an employee is primary over a plan covering the insured person as a dependent; except that if the insured person is also a Medicare beneficiary and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

a) secondary to the plan covering the insured person as a dependent; and

b) primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.

(3) Except as stated in paragraph (4), when this plan and another plan cover the same child as a dependent of different persons, called parents:

a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

b) if both parents have the same birthday, the benefits of the plan covering one parent longer are determined before those of the plan covering the other parent for a shorter period of time.

c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.

(4) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody or as a dependent of the custodial parent's spouse (i.e. step- parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree establishing financial responsibility for the health care expenses with respect to the child, the benefits of a plan covering the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy covering the child as a dependent child.

(5) If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in paragraph (3).

(6) The benefits of a plan covering an insured person as an employee who is neither laid-off nor retired are determined before those of a plan covering that insured person as a laid-off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (6) is ignored.

(7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination.

a) First, the benefits of a plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent).

b) Second, the benefits under the continuation coverage.

c) If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule (7) is ignored.

(8) If none of the above rules determines the order of benefits, the benefits of the plan covering an employee longer are determined before those of the plan covering that insured person for the shorter term.

(9) When determination cannot be made in accordance with the above for Pediatric Benefits, the benefits of a plan that is a medical plan covering dental as a benefit will be primary to a dental only plan.

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

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

We provide You with Contract Dentists at convenient locations within the Delta Dental Service Area in the state of California during the Contract Term. Upon enrollment, We will assign You to a Contract Dentist facility. You may request changes to Your assigned Contract Dentist facility by calling Customer Care at **888-282-8528**. A list of Contract Dentists is available to all Enrollees at **deltadentalins.com**. When searching online for a Contract Dentist, select the DeltaCare USA Network for the list of Contract Dentists applicable to Your plan. Your change must be requested prior to the 15th of the month to become effective on the first day of the following month.

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

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

All Benefits must be performed at Your assigned Contract Dentist facility Specialist Services obtained from a Contract Orthodontist or Contract Specialist must be referred by Your Contract Dentist. With the exception of Emergency Dental Services, Urgent Dental Services and authorized Specialist Services, this Plan does not pay for services received by Out-of-Network Dentists. All authorized Specialist Services claims will be paid by Us, less any applicable Copayment(s).

If Your assigned Contract Dentist facility terminates participation in this Plan, that Contract Dentist facility will complete all Treatment in Progress, as described above. If, for any reason, Your Contract Dentist is unable to complete treatment, We will make reasonable and appropriate provisions for the completion of such treatment by another Contract Dentist. We will give You reasonable advance written notice if You will be materially or adversely affected by the termination, breach of contract or inability of a Contract Dentist to perform services.

Continuity of Care

If You are a current Enrollee, You may have the right to obtain completion of care under this Plan with Your terminated Contract Dentist for certain specified dental conditions. If You are a new Enrollee, You may have the right to completion of care under this Plan with Your Out-of-Network Dentist for certain specified dental conditions. You must make a specific request for this completion of care Benefit. To make a request, contact Our Customer Care at **888-282-8528**. You may also contact Us to request a copy of Our *Continuity of Care Policy*. We are not required to continue care with the Dentist if You are not eligible under this Plan or if We cannot reach agreement with the Out-of-Network Dentist or the terminated Contract Dentist on the terms regarding Enrollee care in accordance with California law.

Emergency Dental Services

Emergency Dental Services are used for palliative relief, controlling of dental pain, and/or stabilizing the Enrollee's condition. Your assigned Contract Dentist facility maintains a 24 hour emergency dental services system, 7 days a week. If You are experiencing an Emergency Dental Condition, You can call **911** (where available) or obtain Emergency Dental Services from any Dentist without a referral.

After Emergency Dental Services are received, further non-emergency treatment is usually needed. Non-emergency treatment must be obtained at Your assigned Contract Dentist facility. You are responsible for any Copayment(s) for Emergency Dental Services received. You are also financially responsible for non-covered services. Non-covered services are not paid by this Plan.

Urgent Dental Services

Inside the Delta Dental Service Area

An Urgent Dental Service requires prompt dental attention but it is not an Emergency Dental Condition. If You believe that You may need Urgent Dental Services, You can call Your assigned Contract Dentist during normal business hours or after hours.

Outside the Delta Dental Service Area

If You need Urgent Dental Services due to an unforeseen dental condition or injury, We cover medically necessary dental services when prompt attention is required from an Out-of-Network Dentist if all of the following are true:

- You receive Urgent Dental Services from an Out-of-Network Dentist while temporarily outside the Delta Dental Service Area.
- You believe that Your health would seriously deteriorate if You delayed treatment until You return to the Delta Dental Service Area.

You do not need prior Authorization from Us to receive Urgent Dental Services outside the Delta Dental Service Area. Any Urgent Dental Services You receive from an Out-of-Network Dentist while outside of the Delta Dental Service Area are covered by this Plan if the Benefits would have been covered if You had received them from a Contract Dentist.

We do not cover follow-up care from an Out-of-Network Dentist after You no longer need Urgent Dental Services. To obtain follow-up care from a Dentist, You can call You assigned Contract Dentist. You are responsible for any Copayment(s) for Urgent Dental Services received.

Timely Access to Care

Contract Dentists, Contract Orthodontists and Contract Specialists have agreed waiting times to Enrollees for appointments for care which will never be greater than the following timeframes:

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

During non-business hours, You will have access to Your assigned Contract Dentist's answering machine, answering service, cell phone or pager for guidance on what to do and whom to contact for Urgent Dental Services or if You are experiencing an Emergency Dental Condition including while outside the Delta Dental Service Area.

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

Language Assistance Services

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

If You need language interpretation services, materials translated into Your preferred language or in an alternative format, please call Customer Care at **888-282-8528 (TTY: 711)**. You may also visit the provider directory on Our website which includes self-reported languages by DeltaCare USA Dentists.

Specialist Services

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

We pay claims for all authorized Specialist Services, less any applicable Copayment(s). If You require Specialist Services and a Contract Specialist or Contract Orthodontist is not within 35 miles of Your home address, Your assigned Contract Dentist must obtain prior Authorization from Us to refer You to an Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist or Out-of-Network orthodontist that are not authorized by Us will not be covered by this Plan. If the services of a Contract Orthodontist are needed, please refer to the Schedules attached to this EOC to determine the Benefits available to You under this Plan.

A Contract Dentist may provide Specialist Services either personally or through associated Dentists, or technicians or hygienists who may lawfully perform these services. If You are referred to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

Claims for Reimbursement

Claims for covered Emergency Dental Services, Urgent Dental Services and authorized Specialist Services should be sent to Us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if You can show that it was not reasonably possible to submit the claim within that time. All dental claims must be received within one (1) year of the treatment date. The address for dental claims is: Delta Dental Claims Department, P.O. Box 1810, Alpharetta, GA 30023-1810.

Dentist Compensation

A Contract Dentist is compensated by Us through monthly capitation (an amount based on the number of Enrollees assigned to the Contract Dentist), and by Enrollees through required Copayments for treatment received. A Contract Specialist and Contract Orthodontist are compensated by Us through an agreed-upon amount for each covered procedure, less the applicable Copayment(s) paid by the Enrollee. In no event do We pay a Contract Dentist, a Contract Specialist or a Contract Orthodontist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

You may obtain further information concerning Dentist compensation by calling Us at **888-282-8528**.

Processing Policies

The dental care guidelines for this Plan explain to Contract Dentists what services are covered under the Contract. Contract Dentists, Contract Specialists and Contract Orthodontists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by a Contract Dentist, Contract Specialist or Contract Orthodontist that fall under the scope of Benefits of this Plan are provided, subject to any applicable Copayment(s). If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Us to determine if the proposed treatment is a

covered Benefit and if it requires treatment by a Contract Specialist. You may call Customer Care at **888-282-8528** for information about this Plan's dental care guidelines.

Teledentistry Services

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

There are two types of Teledentistry services:

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

We cover Teledentistry services at the diagnostic oral evaluation cost share amount shown in *Schedule A* subject to the limitations and exclusions in *Schedule B*. A Teledentistry appointment is covered on the same basis and to the same extent that the Benefit is covered through in-person diagnosis, consultation or treatment and is inclusive in the overall patient management care and not a separately payable service.

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

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

Second Opinion

You may request a second opinion if You disagree with or question the diagnosis and/or treatment plan determination made by Your Contract Dentist. We may also request that You obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be performed by a licensed Dentist in a timely manner, appropriate to the nature of Your condition. Requests involving cases of imminent and serious health threat to Your health including, but not limited to, the potential loss of life, limb or other major bodily function or lack of timeliness that would be detrimental to Your ability to regain maximum function, the second opinion will be expedited (Authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion Authorizations, call Customer Care at **888-282-8528** or write to Us.

Second opinions will be provided at another Contract Dentist facility, unless otherwise authorized by Us. We will authorize a second opinion by an Out-of-Network Dentist if an appropriately qualified Contract Dentist is not available. We will only pay for a second opinion that We have approved or authorized. You will be sent a written notification if We decide not to authorize a second opinion. If You disagree with this determination, You may file a grievance with Us or with the DMHC. Refer to the "Enrollee Claims Complaint Procedure" section below for more information.

Special Health Care Needs

If You believe You have a Special Health Care Need, You should call Customer Care at **888-282-8528 (TTY: 711)**. We will confirm that a Special Health Care Need exists and what arrangements can be made to assist You in obtaining such Benefits. We will not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a DeltaCare USA Dentist treating Enrollees with Special Health Care Needs.

Facility Accessibility

Many dental facilities provide Us with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding dental facility accessibility, call Customer Care at **888-282-8528** or visit Our website at **deltadentalins.com**.

ENROLLEE CLAIMS COMPLAINT PROCEDURE

We, or Our Administrator, will notify You if any dental services or claims are denied, in whole or in part, stating the specific reason(s) for the denial. If You have a complaint regarding eligibility, the denial of dental services or Our claims, policies, procedures or operations or the quality of dental services performed by a Contract Dentist, You may call Customer Care at **888-282-8528 (TTY: 711)**, complete and submit a **DeltaCare USA Enrollee Grievance Form** online or mail Your grievance to:

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

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

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

"Complaint" is the same as "grievance."

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

Within five (5) calendar days of the receipt of any complaint, a quality management coordinator will forward to You a written acknowledgment of the complaint which will include the date of receipt and the name of the plan representative and their contact information. Certain complaints may require that You be referred to a Dentist for clinical evaluation of the dental services provided. We will forward to You a determination, in writing, within 30 calendar days of Our receipt of Your complaint.

Our grievance system ensures all plan Enrollees have access to and can fully participate in Our grievance process by providing assistance for those with limited-English proficiency or with visual or other communicative impairments. Such assistance includes, but is not limited to, translations of grievance procedures, forms and plan responses to grievances as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. If You are in need of these services and/or have questions about Our grievance process, please call Customer Care at **888-282-8528 (TTY: 711)** and/or visit Our website at **deltadentalins.com** to complete and submit a **DeltaCare USA Enrollee Grievance Form**.

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

You may file a complaint with the DMHC after completing Our grievance process or if You have been involved in Our grievance process for more than 30 days. You may seek assistance or file a grievance immediately with the DMHC in cases involving an imminent and serious threat to Your health including, but not limited to, severe pain, potential loss of life, limb or major bodily function. In such case, We will provide You with a written statement on the

disposition or pending status of Your grievance no later than three (3) calendar days from the date of Our receipt of Your grievance. You may file a complaint with the DMHC immediately if You are experiencing an Emergency Dental Condition.

Complaints Involving an Adverse Benefit Determination

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

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

The California Department of Managed Health Care is responsible for regulating health care service plans. If You have a grievance against Your health plan, You should first telephone Your health plan at **888-282-8528** and use Your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to You. If You need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Your health plan, or a grievance that has remained unresolved for more than 30 days, You may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If You are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

GENERAL PROVISIONS

Public Policy Participation by Enrollees

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

Delta Dental of California
P.O. Box 1803
Alpharetta, GA 30023-1803

Severability

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

Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the Contract and/or this EOC, all statements made by You will be deemed representations and not warranties. No such statement will be used in defense to a claim, unless it is contained in a written application.

Legal Actions

No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract and/or this EOC, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required.

Conformity with Applicable Laws

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

Third Party Administrator ("TPA")

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

Organ and Tissue Donation

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

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 or language assistance services, please call Customer Care at **888-282-8528 (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 Care representative or by mail.

Delta Dental Insurance Company
Appeals and Grievances Department
P.O. Box 1860
Alpharetta, GA 30023-1860
888-282-8528 (TTY: 711)
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, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)

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

2027 Dental Standard Benefit Plan Design

Summary of Benefits and Coverage		**Family Dental Plan**	
Member Cost Share amounts describe the Enrollee's out of pocket costs.		**Copay Plan**	
		Pediatric Dental EHB	**Adult Dental**
Children's Dental Plan and Family Dental Plan designs can be offered in both the Individual Marketplace and Covered California for Small Business.		**Up to Age 19**	**Age 19 and Older**
Actuarial Value		89.9%	Not Calculated
Individual Deductible		None	None
Family Deductible (Two or more children)		Not Applicable	Not Applicable
Individual Out of Pocket Maximum		$350	Not Applicable
Family Out of Pocket Maximum (Two or More Children)		$700	Not Applicable
Office Copay		$0	$0
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d).)		None	None
Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)		None	None
Diagnostic & Preventive	Oral Exam	No charge	No charge
	Preventive - Cleaning	No charge	No charge
	Preventive - X-ray	No charge	No charge
	Sealants per Tooth	No charge	No charge if covered
	Topical Fluoride Application	No charge	No charge if covered
	Space Maintainers - Fixed	No charge	No charge if covered
Basic Services	Restorative Procedures	See 2027 Dental Copay Schedule	**See** 2027 Dental Copay Schedule
	Periodontal Maintenance Services		
	Adult Periodontics (other than maintenance) (Group Dental Plans only)		
	Adult Endodontics (Group Dental Plans only)		
Major Services	Periodontics (other than maintenance)	See 2027 Dental Copay Schedule	See 2027 Dental Copay Schedule
	Endodontics		
	Crowns and Casts		
	Prosthodontics		
	Oral Surgery		
Orthodontia	Medically Necessary Orthodontia	$350	Not covered

SCHEDULE A
Description of Benefits and Copayments
DeltaCare® USA
Family Dental HMO
For Small Businesses

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under this Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2026 Procedure Codes, descriptors or nomenclature which is under copyright by the American Dental Association® ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

Pediatric Enrollee	**$350.00** each Contract Year
Multiple Pediatric Enrollees	**$700.00** each Contract Year

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

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

Delta Dental recommends that the Pediatric Enrollee or other party responsible for the Pediatric Enrollee keep a record of payment for Pediatric Benefits. If you have any questions regarding your OOPM, please contact Delta Dental's Customer Care at 888-282-8528.

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0100–D0999 I. DIAGNOSTIC					
D0999	Unspecified diagnostic procedure, by report	No charge	No charge	*Includes office visit, per visit (in addition to other services); In addition, shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	*Includes office visit, per visit (in addition to other services); In addition, shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D0120	Periodic oral evaluation - established patient	No charge	No charge	*1 per 6 months per Contract Dentist*	
D0140	Limited oral evaluation - problem focused	No charge	No charge	*1 per Enrollee per Contract Dentist*	
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge	Not Covered	*1 per 6 months per Contract Dentist, included with D0120, D0150*	
D0150	Comprehensive oral evaluation - new or established patient	No charge	No charge	*Initial evaluation, 1 per Contract Dentist*	
D0160	Detailed and extensive oral evaluation - problem focused, by report	No charge	No charge	*1 per Enrollee per Contract Dentist*	
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No charge	No charge	*6 per 3 months, not to exceed 12 per 12 month period*	
D0171	Re-evaluation - post-operative office visit	No charge	No charge		
D0180	Comprehensive periodontal evaluation - new or established patient	No charge	No charge	*Included with D0150*	
D0190	Screening of a patient	Not Covered	No charge		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0191	Assessment of a patient	Not Covered	No charge		
D0210	Intraoral - comprehensive series of radiographic images	No charge	No charge	*1 series per 36 months per Contract Dentist*	*1 series of (D0210 or D0330) per 24 months*
D0220	Intraoral - periapical first radiographic image	No charge	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*	
D0230	Intraoral - periapical each additional radiographic image	No charge	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*	
D0240	Intraoral - occlusal radiographic image	No charge	No charge	*2 per 6 months per Contract Dentist*	
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	No charge	No charge	*1 per date of service*	
D0251	Extra-oral posterior dental radiographic image	No charge	Not Covered	*4 per date of service*	
D0270	Bitewing - single radiographic image	No charge	No charge	*1 of (D0270, D0273) per date of service*	
D0272	Bitewings - two radiographic images	No charge	No charge	*1 of (D0272, D0273) per 6 months per Contract Dentist*	
D0273	Bitewings - three radiographic images	No charge	No charge	*1 of (D0270, D0273) per date of service; 1 of (D0272, D0273) per 6 months per Contract Dentist*	
D0274	Bitewings - four radiographic images	No charge	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*	*1 series per 6 months*
D0277	Vertical bitewings - 7 to 8 radiographic images	No charge	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*	
D0310	Sialography	No charge	Not Covered		
D0320	Temporomandibular joint arthrogram, including injection	No charge	Not Covered	*Limited to trauma or pathology; 3 per date of service*	
D0322	Tomographic survey	No charge	Not Covered	*2 per 12 months per Contract Dentist*	
D0330	Panoramic radiographic image	No charge	No charge	*1 per 36 months per Contract Dentist*	*1 of (D0210 or D0330) per 24 consecutive months*
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	No charge	Not Covered	*2 per 12 months per Contract Dentist*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No charge	Not Covered	*For the diagnosis and treatment of the specific clinical condition not apparent on radiographs; 4 per date of service*	
D0396	3D printing of a 3D dental surface scan	No charge	No charge		
D0419	Assessment of salivary flow by measurement	Not Covered	No charge		*1 per 12 months*
D0460	Pulp vitality tests	No charge	No charge		
D0461	Testing for cracked tooth	Not Covered	No charge		
D0470	Diagnostic casts	No charge	Not Covered	*For the evaluation of orthodontic Benefits only; 1 per Contract Dentist unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment)*	
D0502	Other oral pathology procedures, by report	No charge	Not Covered	*Performed by an oral pathologist*	
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0701	Panoramic radiographic image - image capture only	No charge	No charge		
D0702	2-D cephalometric radiographic image - image capture only	No charge	No charge		
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No charge	No charge		
D0705	Extra-oral posterior dental radiographic image - image capture only	No charge	Not Covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D0706	Intraoral - occlusal radiographic image - image capture only	No charge	No charge		
D0707	Intraoral - periapical radiographic image - image capture only	No charge	No charge		
D0708	Intraoral - bitewing radiographic image - image capture only	No charge	No charge		
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No charge	No charge		
D0801	3D intraoral surface scan - direct	No charge	Not Covered	*1 per date of service*	
D0802	3D dental surface scan - indirect	No charge	Not Covered	*1 per date of service*	
D0803	3D facial surface scan - direct	No charge	Not Covered	*1 per date of service*	
D0804	3D facial surface scan - indirect	No charge	Not Covered	*1 per date of service*	
D1000-D1999 II. PREVENTIVE					
D1110	Prophylaxis - adult	No charge	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*	*Cleaning; 2 of (D1110, D4346) per 12 months*
D1120	Prophylaxis - child	No charge	Not Covered	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*	
D1206	Topical application of fluoride varnish	No charge	No charge	*2 of (D1206, D1208) per 12 months*	*2 of (D1206, D1208) per 12 months*
D1208	Topical application of fluoride - excluding varnish	No charge	No charge	*2 of (D1206, D1208) per 12 months*	*2 of (D1206, D1208) per 12 months*
D1310	Nutritional counseling for control of dental disease	No charge	No charge		
D1320	Tobacco counseling for the control and prevention of oral disease	No charge	No charge		
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	No charge	Not Covered		
D1330	Oral hygiene instructions	No charge	No charge		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D1351	Sealant - per tooth	No charge	Not Covered	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*	
D1353	Sealant repair - per tooth	No charge	Not Covered	*The original Contract Dentist or dental office is responsible for any repair or replacement during the 36-month period*	
D1354	Application of caries arresting medicament - per tooth	No charge	No charge	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*
D1355	Caries preventive medicament application - per tooth	No charge	Not Covered	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*	
D1510	Space maintainer - fixed, unilateral - per quadrant	No charge	Not Covered	*1 per quadrant; posterior teeth*	
D1516	Space maintainer - fixed - bilateral, maxillary	No charge	Not Covered	*1 per arch; posterior teeth*	
D1517	Space maintainer - fixed - bilateral, mandibular	No charge	Not Covered	*1 per arch; posterior teeth*	
D1520	Space maintainer - removable, unilateral - per quadrant	No charge	Not Covered	*1 per quadrant; posterior teeth*	
D1526	Space maintainer - removable - bilateral, maxillary	No charge	Not Covered	*1 per arch, through age 17; posterior teeth*	
D1527	Space maintainer - removable - bilateral, mandibular	No charge	Not Covered	*1 per arch, through age 17; posterior teeth*	
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No charge	Not Covered	*1 per Contract Dentist, per quadrant or arch, through age 17*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No charge	Not Covered	*1 per Contract Dentist, per quadrant or arch, through age 17*	
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No charge	Not Covered	*1 per Contract Dentist, per quadrant or arch, through age 17*	
D1556	Removal of fixed unilateral space maintainer - per quadrant	No charge	Not Covered	*Included in case by Contract Dentist or dental office who placed appliance*	
D1557	Removal of fixed bilateral space maintainer - maxillary	No charge	Not Covered	*Included in case by Contract Dentist or dental office who placed appliance*	
D1558	Removal of fixed bilateral space maintainer - mandibular	No charge	Not Covered	*Included in case by Contract Dentist or dental office who placed appliance*	
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	No charge	Not Covered	*1 per quadrant, age 8 and under; posterior teeth*	
D2000-D2999 III. RESTORATIVE					
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.					
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years (60+ months) old.					
D2140	Amalgam - one surface, primary or permanent	$25	$25	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2150	Amalgam - two surfaces, primary or permanent	$30	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2160	Amalgam - three surfaces, primary or permanent	$40	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2161	Amalgam - four or more surfaces, primary or permanent	$45	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2330	Resin-based composite - one surface, anterior	$30	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2331	Resin-based composite - two surfaces, anterior	$45	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2332	Resin-based composite - three surfaces, anterior	$55	$55	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2335	Resin-based composite - four or more surfaces (anterior)	$60	$60	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2390	Resin-based composite crown, anterior	$50	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2391	Resin-based composite - one surface, posterior	$30	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2392	Resin-based composite - two surfaces, posterior	$40	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2393	Resin-based composite - three surfaces, posterior	$50	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2394	Resin-based composite - four or more surfaces, posterior	$70	$70	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*	
D2542	Onlay - metallic - two surfaces	Not Covered	$185		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2543	Onlay - metallic - three surfaces	Not Covered	$200		*1 per 60 months*
D2544	Onlay - metallic - four or more surfaces	Not Covered	$215		*1 per 60 months*
D2642	Onlay - porcelain/ceramic - two surfaces	Not Covered	$250		*1 per 60 months*
D2643	Onlay - porcelain/ceramic - three surfaces	Not Covered	$275		*1 per 60 months*
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not Covered	$300		*1 per 60 months*
D2662	Onlay - resin-based composite - two surfaces	Not Covered	$160		*1 per 60 months*
D2663	Onlay - resin-based composite - three surfaces	Not Covered	$180		*1 per 60 months*
D2664	Onlay - resin-based composite - four or more surfaces	Not Covered	$200		*1 per 60 months*
D2710	Crown - resin-based composite (indirect)	$140	$140	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2712	Crown - 3/4 resin-based composite (indirect)	$190	$200	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2720	Crown - resin with high noble metal	Not Covered	$300		*1 per 60 months*
D2721	Crown - resin with predominantly base metal	$300	$300	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2722	Crown - resin with noble metal	Not Covered	$300		*1 per 60 months*
D2740	Crown - porcelain/ceramic	$300	$300	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2750	Crown - porcelain fused to high noble metal	Not Covered	$300		*1 per 60 months*
D2751	Crown - porcelain fused to predominantly base metal	$300	$300	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2752	Crown - porcelain fused to noble metal	Not Covered	$300		*1 per 60 months*
D2753	Crown - porcelain fused to titanium and titanium alloys	Not Covered	$300		*1 per 60 months*
D2780	Crown - 3/4 cast high noble metal	Not Covered	$300		*1 per 60 months*
D2781	Crown - 3/4 cast predominantly base metal	$300	$300	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2782	Crown - 3/4 cast noble metal	Not Covered	$300		*1 per 60 months*
D2783	Crown - 3/4 porcelain/ceramic	$310	$310	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2790	Crown - full cast high noble metal	Not Covered	$300		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2791	Crown - full cast predominantly base metal	$300	$300	*1 per 60 months, permanent teeth; age 13 through 18*	*1 per 60 months*
D2792	Crown - full cast noble metal	Not Covered	$300		*1 per 60 months*
D2794	Crown - titanium and titanium alloys	Not Covered	$300		*1 per 60 months*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$25	$25	*1 per 12 months per Contract Dentist*	
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$25	$25		
D2920	Re-cement or re-bond crown	$25	$15	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45	$45	*1 per 12 months*	*Anterior tooth; 1 per 24 months*
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$120	Not Covered	*1 per 36 months*	
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95	Not Covered	*1 per 12 months*	
D2930	Prefabricated stainless steel crown - primary tooth	$65	Not Covered	*1 per 12 months*	
D2931	Prefabricated stainless steel crown - permanent tooth	$75	$75	*1 per 36 months*	
D2932	Prefabricated resin crown	$75	Not Covered	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*	
D2933	Prefabricated stainless steel crown with resin window	$80	Not Covered	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*	
D2940	Placement of interim direct restoration	$25	$20	*1 per 6 months per Contract Dentist*	
D2949	Restorative foundation for an indirect restoration	$45	Not Covered		
D2950	Core buildup, including any pins when required	$20	$20		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2951	Pin retention - per tooth, in addition to restoration	$25	$20	*1 per tooth regardless of the number of pins placed; permanent teeth*	
D2952	Post and core in addition to crown, indirectly fabricated	$100	$60	*Base metal post; 1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*	*Base metal post; includes canal preparation*
D2953	Each additional indirectly fabricated post - same tooth	$30	$30	*Performed in conjunction with D2952*	
D2954	Prefabricated post and core in addition to crown	$90	$60	*1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*	*Includes canal preparation*
D2955	Post removal	$60	Not Covered	*Included in case fee by Contract Dentist or dental office who performed endodontic and restorative procedures. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D2957	Each additional prefabricated post - same tooth	$35	$35	*Performed in conjunction with D2954*	
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	$35	Not Covered	*Included in the fee for laboratory processed crowns. The listed fee applies for service provided by a Contract Dentist other than the original treating Dentist/dental office.*	
D2976	Band stabilization – per tooth	$40	$40	*1 per tooth per lifetime*	*1 per tooth per lifetime*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D2980	Crown repair necessitated by restorative material failure	$50	$50	*Repair during the 12 months following initial placement or previous repair is included, no additional charge to the Enrollee or plan is permitted by the original treating Contract Dentist/dental office.*	
D2989	Excavation of a tooth resulting in the determination of non-restorability	$50	$50		
D2991	Application of hydroxyapatite regeneration medicament – per tooth	No charge	No charge	*2 per tooth per 12 months*	*2 per tooth per 12 months*
D2999	Unspecified restorative procedure, by report	$40	$40	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D3000-D3999 IV. ENDODONTICS					
D3110	Pulp cap - direct (excluding final restoration)	$20	$20		
D3120	Pulp cap - indirect (excluding final restoration)	$25	$25		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$40	Not Covered	*1 per primary tooth*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3221	Pulpal debridement, primary and permanent teeth	$40	$50	*1 per tooth*	
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60	Not Covered	*1 per permanent tooth*	
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$55	Not Covered	*1 per tooth*	
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$55	Not Covered	*1 per tooth*	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$195	$200	*Root canal*	*Root canal*
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$235	$235	*Root canal*	*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$300	$300	*Root canal*	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$50	$50		
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Not Covered	$85		
D3333	Internal root repair of perforation defects	$80	$80		
D3346	Retreatment of previous root canal therapy - anterior	$240	$245	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3347	Retreatment of previous root canal therapy - premolar	$295	$295	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D3348	Retreatment of previous root canal therapy - molar	$350	$350	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$85	Not Covered	*1 per permanent tooth*	
D3352	Apexification/recalcification - interim medication replacement	$45	Not Covered	*1 per permanent tooth*	
D3410	Apicoectomy - anterior	$240	$240	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*	
D3421	Apicoectomy - premolar (first root)	$250	$250	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*	
D3425	Apicoectomy - molar (first root)	$275	$275	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3426	Apicoectomy (each additional root)	$110	$110	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only; a benefit for 3rd molar if it occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.*	
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	$350	Not Covered		
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$350	Not Covered		
D3430	Retrograde filling - per root	$90	$90		
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	$80	Not Covered		
D3450	Root amputation - per root	Not Covered	$110		
D3471	Surgical repair of root resorption - anterior	$160	$160	*1 per 24 months by the same Contract Dentist or dental office*	
D3472	Surgical repair of root resorption - premolar	$160	$160	*1 per 24 months by the same Contract Dentist or dental office*	
D3473	Surgical repair of root resorption - molar	$160	$160	*1 per 24 months by the same Contract Dentist or dental office*	
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	Not Covered		
D3920	Hemisection (including any root removal), not including root canal therapy	Not Covered	$120		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D3999	Unspecified endodontic procedure, by report	$100	$100	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D4000-D4999 V. PERIODONTICS					
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.					
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$150	$150	*1 per quadrant per 36 months, age 13+*	
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50	$50	*1 per quadrant per 36 months, age 13+*	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Not Covered	$135		
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	Not Covered	$70		
D4249	Clinical crown lengthening - hard tissue	$165	$200		
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$265	$265	*1 per quadrant per 36 months, age 13+*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$140	$140	*1 per quadrant per 36 months, age 13+*	
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	Not Covered	$105		
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	Not Covered	$75		
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	$80	Not Covered		
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site	Not Covered	$145		
D4267	Guided tissue regeneration, natural teeth – non-resorbable barrier, per site	Not Covered	$175		
D4270	Pedicle soft tissue graft procedure	Not Covered	$155		
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	Not Covered	$220		
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	Not Covered	$190		*1 per quadrant per 36 months*
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered	$185		
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered	$175		*1 per quadrant per 36 months*
D4286	Removal of non-resorbable barrier	Not Covered	$175		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$55	$55	*1 per quadrant per 24 months; age 13+*	*4 quadrants per 12 consecutive months*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30	$25	*1 per quadrant per 24 months; age 13+*	*4 quadrants per 12 consecutive months*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$40	$40	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*	*Cleaning; limited to 2 of (D1110, D4346) per 12 months*
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$40	$40	*1 treatment per 12 consecutive months*	*1 treatment per 12 consecutive months*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10	$10		
D4910	Periodontal maintenance	$30	$30	*1 per 3 months; service must be within the 24 months following the last scaling and root planing*	*2 treatments per 12 months*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$15	Not Covered	*1 per Contract Dentist; age 13+*	
D4999	Unspecified periodontal procedure, by report	$350	$350	*Enrollees age 13+. Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5000-D5899 VI. PROSTHODONTICS (removable)					
- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.					
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.					
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years (60+ months) old.					
D5110	Complete denture - maxillary	$300	$400	*1 per 60 months*	*1 per 60 months*
D5120	Complete denture - mandibular	$300	$400	*1 per 60 months*	*1 per 60 months*
D5130	Immediate denture - maxillary	$300	$400	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*	*1 per 60 months*
D5140	Immediate denture - mandibular	$300	$400	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*	*1 per 60 months*
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$300	$325	*1 per 60 months*	*1 per 60 months*
D5212	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$300	$325	*1 per 60 months*	*1 per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$335	$375	*1 per 60 months*	*1 per 60 months*
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$335	$375	*1 per 60 months*	*1 per 60 months*
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$275	$300	*1 per 60 months*	*1 per 60 months*
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$275	$300	*1 per 60 months*	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$330	$370	*1 per 60 months*	*1 per 60 months*
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$330	$370	*1 per 60 months*	*1 per 60 months*
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not Covered	$375		*1 per 60 months*
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Not Covered	$375		*1 per 60 months*
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not Covered	$375		*1 per 60 months*
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not Covered	$375		*1 per 60 months*
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	Not Covered	$250		*1 per 60 months*
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	Not Covered	$250		*1 per 60 months*
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant	Not Covered	$250		*1 per 60 months*
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant	Not Covered	$250		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5410	Adjust complete denture - maxillary	$20	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*	
D5411	Adjust complete denture - mandibular	$20	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*	
D5421	Adjust partial denture - maxillary	$20	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*	
D5422	Adjust partial denture - mandibular	$20	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*	
D5511	Repair broken complete denture base, mandibular	$40	$30	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*	
D5512	Repair broken complete denture base, maxillary	$40	$30	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*	
D5520	Replace missing or broken teeth - complete denture – per tooth	$40	$30	*Up to 4 per arch per date of service after the initial 6 months; up to 2 per arch per 12 months per Contract Dentist*	
D5611	Repair resin partial denture base, mandibular	$40	$30	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5612	Repair resin partial denture base, maxillary	$40	$30	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*	
D5621	Repair cast partial framework, mandibular	$40	$35	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*	
D5622	Repair cast partial framework, maxillary	$40	$35	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*	
D5630	Repair or replace broken retentive/clasping materials - per tooth	$50	$30	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*	
D5640	Replace missing or broken teeth – partial denture - per tooth	$35	$30	*4 per arch per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*	
D5650	Add tooth to existing partial denture – per tooth	$35	$35	*Up to 3 per date of service per Contract Dentist; 1 per tooth after the initial 6 months*	
D5660	Add clasp to existing partial denture - per tooth	$60	$45	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*	
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not Covered	$195		
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not Covered	$195		
D5710	Rebase complete maxillary denture	Not Covered	$155		*1 per 12 months*
D5711	Rebase complete mandibular denture	Not Covered	$155		*1 per 12 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5720	Rebase maxillary partial denture	Not Covered	$150		*1 per 12 months*
D5721	Rebase mandibular partial denture	Not Covered	$150		*1 per 12 months*
D5730	Reline complete maxillary denture (direct)	$60	$80	*Included for the first 6 months after placement by the Contract Dentist or dental office where the appliance was originally delivered; 1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5731	Reline complete mandibular denture (direct)	$60	$80	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5740	Reline maxillary partial denture (direct)	$60	$75	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5741	Reline mandibular partial denture (direct)	$60	$75	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5750	Reline complete maxillary denture (indirect)	$90	$120	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5751	Reline complete mandibular denture (indirect)	$90	$120	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5760	Reline maxillary partial denture (indirect)	$80	$110	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5761	Reline mandibular partial denture (indirect)	$80	$110	*1 per 12 month period after the initial 6 months*	*1 per 12 months*
D5850	Tissue conditioning, maxillary	$30	$35	*2 per prosthesis per 36 months after the initial 6 months*	*1 per 12 months*
D5851	Tissue conditioning, mandibular	$30	$35	*2 per prosthesis per 36 months after the initial 6 months*	*1 per 12 months*
D5862	Precision attachment, by report	$90	Not Covered	*Included in the fee for prosthetic and restorative procedures by the Contract Dentist or dental office where the service was originally delivered. The listed fee applies for service provided by a dentist other than the original treating Contract Dentist or dental office.*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5863	Overdenture - complete maxillary - natural tooth borne	$300	Not Covered	*1 per 60 months*	
D5864	Overdenture - partial maxillary - natural tooth borne	$300	Not Covered	*1 per 60 months*	
D5865	Overdenture - complete mandibular - natural tooth borne	$300	Not Covered	*1 per 60 months*	
D5866	Overdenture - partial mandibular - natural tooth borne	$300	Not Covered	*1 per 60 months*	
D5899	Unspecified removable prosthodontic procedure, by report	$350	$400	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS					
- All maxillofacial prosthetic procedures require prior Authorization.					
D5909	Maxillary guidance prosthesis with guide flange	$350	Not Covered		
D5911	Facial moulage (sectional)	$285	Not Covered		
D5912	Facial moulage (complete)	$350	Not Covered		
D5913	Nasal prosthesis	$350	Not Covered		
D5914	Auricular prosthesis	$350	Not Covered		
D5915	Orbital prosthesis	$350	Not Covered		
D5916	Ocular prosthesis	$350	Not Covered		
D5919	Facial prosthesis	$350	Not Covered		
D5922	Nasal septal prosthesis	$350	Not Covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5923	Ocular prosthesis, interim	$350	Not Covered		
D5924	Cranial prosthesis	$350	Not Covered		
D5925	Facial augmentation implant prosthesis	$200	Not Covered		
D5926	Nasal prosthesis, replacement	$200	Not Covered		
D5927	Auricular prosthesis, replacement	$200	Not Covered		
D5928	Orbital prosthesis, replacement	$200	Not Covered		
D5929	Facial prosthesis, replacement	$200	Not Covered		
D5930	Maxillary guidance prosthesis without guide flange	$350	Not covered		
D5931	Obturator prosthesis, surgical	$350	Not Covered		
D5932	Obturator prosthesis, definitive	$350	Not Covered		
D5933	Obturator prosthesis, modification	$150	Not Covered	*2 per 12 months*	
D5934	Mandibular guidance prosthesis with guide flange	$350	Not Covered		
D5935	Mandibular guidance prosthesis without guide flange	$350	Not Covered		
D5936	Obturator prosthesis, interim	$350	Not Covered		
D5937	Trismus appliance (not for TMD treatment)	$85	Not Covered		
D5938	Resection prosthesis, maxillary complete removable	$350	$350		1 per 60 months
D5939	Resection prosthesis, mandibular complete removable	$350	$350		1 per 60 months
D5940	Resection prosthesis, maxillary partial removable	$350	$350		1 per 60 months
D5941	Resection prosthesis, mandibular partial removable	$350	$350		1 per 60 months
D5942	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for edentulous arch	$350	Not Covered		
D5943	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for edentulous arch	$350	Not Covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5944	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for the partial edentulous arch	$350	Not Covered		
D5945	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for the partial edentulous arch	$350	Not Covered		
D5946	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for edentulous arch	$350	Not Covered		
D5947	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for edentulous arch	$350	Not Covered		
D5948	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for the partial edentulous arch	$350	Not Covered		
D5949	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for the partial edentulous arch	$350	Not Covered		
D5951	Feeding aid	$135	Not Covered		
D5952	Speech aid prosthesis, pediatric	$350	Not Covered		
D5953	Speech aid prosthesis, adult	$350	Not Covered		
D5954	Palatal augmentation prosthesis	$135	Not Covered		
D5955	Palatal lift prosthesis, definitive	$350	Not Covered		
D5958	Palatal lift prosthesis, interim	$350	Not Covered		
D5959	Palatal lift prosthesis, modification	$145	Not Covered	*2 per 12 months*	
D5960	Speech aid prosthesis, modification	$145	Not Covered	*2 per 12 months*	
D5982	Surgical stent for soft tissue healing	$70	Not Covered		
D5983	Radiation carrier	$55	Not Covered		
D5984	Radiation shield	$85	Not Covered		
D5985	Radiation cone locator	$135	Not Covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D5986	Fluoride gel carrier	$35	Not Covered		
D5987	Commissure splint	$85	Not Covered		
D5988	Surgical splint	$95	Not Covered		
D5991	Vesiculobullous disease medicament carrier	$70	Not Covered		
D5999	Unspecified maxillofacial prosthesis, by report	$350	Not Covered	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	
D6000-D6199 VIII. IMPLANT SERVICES					
- A Benefit only under exceptional medical conditions. Prior Authorization is required. Refer also to Schedule B.					
D6010	Surgical placement of implant body: endosteal implant	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6011	Surgical access to an implant body (second stage implant surgery)	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6013	Surgical placement of mini implant	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6040	Surgical placement: eposteal implant	$350	Not Covered	*A Benefit only under exceptional medical conditions*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6049	Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure	$35	Not Covered		
D6050	Surgical placement: transosteal implant	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6055	Connecting bar - implant supported or abutment supported	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6056	Prefabricated abutment - includes modification and placement	$135	Not Covered	*A Benefit only under exceptional medical conditions*	
D6057	Custom fabricated abutment - includes placement	$180	Not Covered	*A Benefit only under exceptional medical conditions*	
D6058	Abutment supported porcelain/ceramic crown	$320	Not Covered	*A Benefit only under exceptional medical conditions*	
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315	Not Covered	*A Benefit only under exceptional medical conditions*	
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295	Not Covered	*A Benefit only under exceptional medical conditions*	
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300	Not Covered	*A Benefit only under exceptional medical conditions*	
D6062	Abutment supported cast metal crown (high noble metal)	$315	Not Covered	*A Benefit only under exceptional medical conditions*	
D6063	Abutment supported cast metal crown (predominantly base metal)	$300	Not Covered	*A Benefit only under exceptional medical conditions*	
D6064	Abutment supported cast metal crown (noble metal)	$315	Not Covered	*A Benefit only under exceptional medical conditions*	
D6065	Implant supported porcelain/ceramic crown	$340	Not Covered	*A Benefit only under exceptional medical conditions*	
D6066	Implant supported crown - porcelain fused to high noble alloys	$335	Not Covered	*A Benefit only under exceptional medical conditions*	
D6067	Implant supported crown - high noble alloys	$340	Not Covered	*A Benefit only under exceptional medical conditions*	
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320	Not Covered	*A Benefit only under exceptional medical conditions*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315	Not Covered	*A Benefit only under exceptional medical conditions*	
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290	Not Covered	*A Benefit only under exceptional medical conditions*	
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300	Not Covered	*A Benefit only under exceptional medical conditions*	
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315	Not Covered	*A Benefit only under exceptional medical conditions*	
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290	Not Covered	*A Benefit only under exceptional medical conditions*	
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320	Not Covered	*A Benefit only under exceptional medical conditions*	
D6075	Implant supported retainer for ceramic FPD	$335	Not Covered	*A Benefit only under exceptional medical conditions*	
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$330	Not Covered	*A Benefit only under exceptional medical conditions*	
D6077	Implant supported retainer for metal FPD - high noble alloys	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	$30	Not Covered	*A Benefit only under exceptional medical conditions*	
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	$30	Not Covered	*A Benefit only under exceptional medical conditions*	
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$335	Not Covered	*A Benefit only under exceptional medical conditions.*	
D6083	Implant supported crown - porcelain fused to noble alloys	$335	Not Covered	*A Benefit only under exceptional medical conditions*	
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$335	Not Covered	*A Benefit only under exceptional medical conditions*	
D6085	Interim implant crown	$300	Not Covered	*A Benefit only under exceptional medical conditions*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6086	Implant supported crown - predominantly base alloys	$340	Not Covered	*A Benefit only under exceptional medical conditions*	
D6087	Implant supported crown - noble alloys	$340	Not Covered	*A Benefit only under exceptional medical conditions*	
D6088	Implant supported crown - titanium and titanium alloys	$340	Not Covered	*A Benefit only under exceptional medical conditions*	
D6089	Accessing and retorquing loose implant screw - per screw	$60	Not Covered	*1 per 24 months*	
D6090	Repair of implant/abutment supported prosthesis	$65	Not Covered	*A Benefit only under exceptional medical conditions*	
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$40	Not Covered	*A Benefit only under exceptional medical conditions*	
D6092	Re-cement or re-bond implant/abutment supported crown	$25	Not Covered	*A Benefit only under exceptional medical conditions*	
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$35	Not Covered	*A Benefit only under exceptional medical conditions*	
D6094	Abutment supported crown - titanium and titanium alloys	$295	Not Covered	*A Benefit only under exceptional medical conditions*	
D6096	Remove broken implant retaining screw	$60	Not Covered	*A Benefit only under exceptional medical conditions*	
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$315	Not Covered	*A Benefit only under exceptional medical conditions*	
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330	Not Covered	*A Benefit only under exceptional medical conditions*	
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$330	Not Covered	*A Benefit only under exceptional medical conditions*	
D6100	Surgical removal of implant body	$110	Not Covered	*A Benefit only under exceptional medical conditions*	
D6105	Removal of implant body not requiring bone removal or flap elevation	$110	Not Covered	*A Benefit only under exceptional medical conditions*	
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350	Not Covered	*A Benefit only under exceptional medical conditions*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$330	Not Covered	*A Benefit only under exceptional medical conditions*	
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6122	Implant supported retainer for metal FPD - noble alloys	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	$30	Not Covered	*A Benefit only under exceptional medical conditions*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6190	Radiographic/surgical implant index, by report	$75	Not Covered	*A Benefit only under exceptional medical conditions*	
D6191	Semi-precision abutment - placement	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6192	Semi-precision attachment - placement	$350	Not Covered	*A Benefit only under exceptional medical conditions*	
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	$265	Not Covered	*A Benefit only under exceptional medical conditions*	
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315	Not Covered	*A Benefit only under exceptional medical conditions*	
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$95	Not Covered	*A Benefit only under exceptional medical conditions*	
D6198	Remove interim implant component	$110	Not Covered	*A Benefit only under exceptional medical conditions*	
D6199	Unspecified implant procedure, by report	$350	Not Covered	*Implant services are a Benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Written documentation shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.*	
D6200-D6999 IX. PROSTHODONTICS, fixed					
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge).					
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years (60+ months) old.					
D6205	Pontic - indirect resin based composite	Not Covered	$165		*1 per 60 months*
D6210	Pontic - cast high noble metal	Not Covered	$300		*1 per 60 months*
D6211	Pontic - cast predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6212	Pontic - cast noble metal	Not Covered	$300		*1 per 60 months*
D6214	Pontic - titanium and titanium alloys	Not Covered	$300		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6240	Pontic - porcelain fused to high noble metal	Not Covered	$300		*1 per 60 months*
D6241	Pontic - porcelain fused to predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6242	Pontic - porcelain fused to noble metal	Not Covered	$300		*1 per 60 months*
D6243	Pontic - porcelain fused to titanium and titanium alloys	Not Covered	$300		*1 per 60 months*
D6245	Pontic - porcelain/ceramic	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6250	Pontic - resin with high noble metal	Not Covered	$300		*1 per 60 months*
D6251	Pontic - resin with predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6252	Pontic - resin with noble metal	Not Covered	$300		*1 per 60 months*
D6280	Implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments - per arch	$20	Not Covered		
D6608	Retainer onlay - porcelain/ceramic, two surfaces	Not Covered	$200		*1 per 60 months*
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	Not Covered	$200		*1 per 60 months*
D6610	Retainer onlay - cast high noble metal, two surfaces	Not Covered	$200		*1 per 60 months*
D6611	Retainer onlay - cast high noble metal, three or more surfaces	Not Covered	$200		*1 per 60 months*
D6612	Retainer onlay - cast predominantly base metal, two surfaces	Not Covered	$200		*1 per 60 months*
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	Not Covered	$200		*1 per 60 months*
D6614	Retainer onlay - cast noble metal, two surfaces	Not Covered	$200		*1 per 60 months*
D6615	Retainer onlay - cast noble metal, three or more surfaces	Not Covered	$200		*1 per 60 months*
D6710	Retainer crown - indirect resin based composite	Not Covered	$200		*1 per 60 months*
D6720	Retainer crown - resin with high noble metal	Not Covered	$300		*1 per 60 months*
D6721	Retainer crown - resin with predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6722	Retainer crown - resin with noble metal	Not Covered	$300		*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6740	Retainer crown - porcelain/ceramic	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6750	Retainer crown - porcelain fused to high noble metal	Not Covered	$300		*1 per 60 months*
D6751	Retainer crown - porcelain fused to predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6752	Retainer crown - porcelain fused to noble metal	Not Covered	$300		*1 per 60 months*
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	Not Covered	$300		*1 per 60 months*
D6781	Retainer crown - 3/4 cast predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6782	Retainer crown - 3/4 cast noble metal	Not Covered	$300		*1 per 60 months*
D6783	Retainer crown - 3/4 porcelain/ceramic	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6784	Retainer crown - 3/4 titanium and titanium alloys	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6791	Retainer crown - full cast predominantly base metal	$300	$300	*1 per 60 months; age 13+*	*1 per 60 months*
D6794	Retainer crown - titanium and titanium alloys	Not Covered	$300		*1 per 60 months*
D6930	Re-cement or re-bond fixed partial denture	$40	$40	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D6980	Fixed partial denture repair necessitated by restorative material failure	$95	$95		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D6999	Unspecified fixed prosthodontic procedure, by report	$350	$400	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment. Not a Benefit within 12 months of initial placement of a fixed partial denture by the same Contract Dentist/office.*	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY					
- Prior Authorization required for procedures performed by a Contract Specialist. Medical necessity must be demonstrated for procedures D7340 - D7997. Refer also to Schedule B.					
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic. Post-operative services include exams, suture removal and treatment of complications.					
D7111	Extraction, coronal remnants - primary tooth	$40	$40		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65	$65		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$120	$115		
D7220	Removal of impacted tooth - soft tissue	$95	$85		
D7230	Removal of impacted tooth - partially bony	$145	$145		
D7240	Removal of impacted tooth - completely bony	$160	$160		
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175	$175		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7250	Removal of residual tooth roots (cutting procedure)	$80	$75		
D7252	Partial extraction for immediate implant placement	$80	Not Covered	*1 per lifetime per tooth, in conjunction with immediate implant placement*	
D7259	Nerve dissection	$280	Not Covered		
D7260	Oroantral fistula closure	$280	Not Covered		
D7261	Primary closure of a sinus perforation	$285	Not Covered		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$185	$185	*1 per arch regardless of number of teeth involved; permanent anterior teeth*	
D7280	Exposure of an unerupted tooth	$220	$220		
D7283	Placement of device to facilitate eruption of impacted tooth	$85	Not Covered	*For active orthodontic treatment only*	
D7284	Excisional biopsy of minor salivary glands	$115	$115	*1 in same day*	*1 in same day*
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$180	Not Covered	*1 per arch per date of service; regardless of number of areas involved*	
D7286	Incisional biopsy of oral tissue-soft	$110	$110	*3 per date of service*	*1 in same day*
D7290	Surgical repositioning of teeth	$185	Not Covered	*1 per arch, for permanent teeth only; applies to active orthodontic treatment*	
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	Not Covered	*1 per arch; applies to active orthodontic treatment*	
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$85	$85		
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50	$50		
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$120	$120		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65	$65		
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$350	Not Covered	*1 per arch per 60 months*	
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350	Not Covered	*1 per arch*	
D7410	Excision of benign lesion up to 1.25 cm	$75	Not Covered		
D7411	Excision of benign lesion greater than 1.25 cm	$115	Not Covered		
D7412	Excision of benign lesion, complicated	$175	Not Covered		
D7413	Excision of malignant lesion up to 1.25 cm	$95	Not Covered		
D7414	Excision of malignant lesion greater than 1.25 cm	$120	Not Covered		
D7415	Excision of malignant lesion, complicated	$255	Not Covered		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$105	Not Covered		
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$185	Not Covered		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180	$180		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330	$330		
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155	Not Covered		
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250	Not Covered		
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	Not Covered		
D7471	Removal of lateral exostosis (maxilla or mandible)	$140	$140	*1 per quadrant*	
D7472	Removal of torus palatinus	$145	$140	*1 per lifetime*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7473	Removal of torus mandibularis	$140	$140	*1 per quadrant*	
D7485	Reduction of osseous tuberosity	$105	Not Covered	*1 per quadrant*	
D7490	Radical resection of maxilla or mandible	$350	Not Covered		
D7509	Marsupialization of odontogenic cyst	$180	$180		
D7510	Incision and drainage of abscess - intraoral soft tissue	$70	$55	*1 per quadrant per date of service*	
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$70	Not Covered	*1 per quadrant per date of service*	
D7520	Incision and drainage of abscess - extraoral soft tissue	$70	Not Covered		
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80	Not Covered		
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45	Not Covered	*1 per date of service*	
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	Not Covered	*1 per date of service*	
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	Not Covered	*1 per quadrant per date of service*	
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	Not Covered		
D7610	Maxilla - open reduction (teeth immobilized, if present)	$140	Not Covered		
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$250	Not Covered		
D7630	Mandible - open reduction (teeth immobilized, if present)	$350	Not Covered		
D7640	Mandible - closed reduction (teeth immobilized, if present)	$350	Not Covered		
D7650	Malar and/or zygomatic arch - open reduction	$350	Not Covered		
D7660	Malar and/or zygomatic arch - closed reduction	$350	Not Covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7670	Alveolus - closed reduction, may include stabilization of teeth	$170	Not Covered		
D7671	Alveolus - open reduction, may include stabilization of teeth	$230	Not Covered		
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350	Not Covered		
D7710	Maxilla - open reduction	$110	Not Covered		
D7720	Maxilla - closed reduction	$180	Not Covered		
D7730	Mandible - open reduction	$350	Not Covered		
D7740	Mandible - closed reduction	$290	Not Covered		
D7750	Malar and/or zygomatic arch - open reduction	$220	Not Covered		
D7760	Malar and/or zygomatic arch - closed reduction	$350	Not Covered		
D7770	Alveolus - open reduction stabilization of teeth	$135	Not Covered		
D7771	Alveolus, closed reduction stabilization of teeth	$160	Not Covered		
D7780	Facial bones - complicated reduction with fixation and multiple approaches	$350	Not Covered		
D7810	Open reduction of dislocation	$350	Not Covered		
D7820	Closed reduction of dislocation	$80	Not Covered		
D7830	Manipulation under anesthesia	$85	Not Covered		
D7840	Condylectomy	$350	Not Covered		
D7850	Surgical discectomy, with/without implant	$350	Not Covered		
D7852	Disc repair	$350	Not Covered		
D7854	Synovectomy	$350	Not Covered		
D7856	Myotomy	$350	Not Covered		
D7858	Joint reconstruction	$350	Not Covered		
D7860	Arthrotomy	$350	Not Covered		
D7865	Arthroplasty	$350	Not Covered		
D7870	Arthrocentesis	$90	Not Covered		
D7871	Non-arthroscopic lysis and lavage	$150	Not Covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7872	Arthroscopy - diagnosis, with or without biopsy	$350	Not Covered		
D7873	Arthroscopy: lavage and lysis of adhesions	$350	Not Covered		
D7874	Arthroscopy: disc repositioning and stabilization	$350	Not Covered		
D7875	Arthroscopy: synovectomy	$350	Not Covered		
D7876	Arthroscopy: discectomy	$350	Not Covered		
D7877	Arthroscopy: debridement	$350	Not Covered		
D7880	Occlusal orthotic device, by report	$120	Not Covered		
D7881	Occlusal orthotic device adjustment	$30	Not Covered	*1 per date of service per Contract Dentist; 2 per 12 months per Contract Dentist*	
D7899	Unspecified TMD therapy, by report	$350	Not Covered		
D7910	Suture of recent small wounds up to 5 cm	$35	Not Covered		
D7911	Complicated suture - up to 5 cm	$55	Not Covered		
D7912	Complicated suture - greater than 5 cm	$130	Not Covered		
D7920	Skin graft (identify defect covered, location and type of graft)	$120	Not Covered		
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80	$80		
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	$350	Not Covered	*1 per tooth per 60 months*	
D7940	Osteoplasty - for orthognathic deformities	$160	Not Covered		
D7941	Osteotomy - mandibular rami	$350	Not Covered		
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350	Not Covered		
D7944	Osteotomy - segmented or subapical	$275	Not Covered		
D7945	Osteotomy - body of mandible	$350	Not Covered		
D7946	LeFort I (maxilla - total)	$350	Not Covered		
D7947	LeFort I (maxilla - segmented)	$350	Not Covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350	Not Covered		
D7949	LeFort II or LeFort III - with bone graft	$350	Not Covered		
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	$190	Not Covered		
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	Not Covered		
D7952	Sinus augmentation via a vertical approach	$175	Not Covered		
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	Not Covered		
D7961	Buccal/labial frenectomy (frenulectomy)	$120	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*	
D7962	Lingual frenectomy (frenulectomy)	$120	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*	
D7963	Frenuloplasty	$120	Not Covered	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*	
D7970	Excision of hyperplastic tissue - per arch	$175	$176	*1 per arch per date of service*	
D7971	Excision of pericoronal gingiva	$80	$80		
D7972	Surgical reduction of fibrous tuberosity	$100	Not Covered	*1 per quadrant per date of service*	
D7979	Non-surgical sialolithotomy	$155	Not Covered		
D7980	Surgical sialolithotomy	$155	Not Covered		
D7981	Excision of salivary gland, by report	$120	Not Covered		
D7982	Sialodochoplasty	$215	Not Covered		
D7983	Closure of salivary fistula	$140	Not Covered		
D7990	Emergency tracheotomy	$350	Not Covered		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D7991	Coronoidectomy	$345	Not Covered		
D7995	Synthetic graft - mandible or facial bones, by report	$150	Not Covered		
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	Not Covered	*Removal of appliances related to surgical procedures only; 1 per arch per date of service; the listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*	
D7999	Unspecified oral surgery procedure, by report	$350	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees ONLY

- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

- Pediatric Enrollee must continue to be eligible. Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.

- Comprehensive orthodontic treatment procedure (D8080) includes all appliances, adjustments, insertion, removal and post treatment stabilization (retention). The Enrollee must continue to be eligible during active treatment. No additional charge to the Enrollee is permitted from the original treating Contract Orthodontist or dental office who received the comprehensive case fee. A separate fee applies for services provided by a Contract Orthodontist other than the original treating Contract Orthodontist or dental office.

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
- Limited orthodontic treatment (any dentition) and Comprehensive orthodontic treatment (any dentition) are part of Comprehensive orthodontic treatment with orthognathic surgery.					
- Copayment for medically necessary orthodontics applies to course of treatment, not individual benefit years within a multi-year course of treatment. This Copayment applies to the course of treatment as long as the Pediatric Enrollee remains enrolled in this Plan.					
- Refer to Schedule B for additional information on medically necessary orthodontics.					
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350	Not Covered	*1 per Enrollee per phase of treatment*	
D8091	Comprehensive orthodontic treatment with orthognathic surgery			*1 per Enrollee per phase of treatment*	
D8210	Removable appliance therapy			*1 per lifetime; age 6 through 12*	
D8220	Fixed appliance therapy			*1 per lifetime; age 6 through 12*	
D8660	Pre-orthodontic treatment examination to monitor growth and development			*1 per 3 months when performed by the same Contract Dentist or dental office; up to 6 visits per lifetime*	
D8670	Periodic orthodontic treatment visit			*Included in comprehensive case fee*	
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery			*Included in comprehensive case fee*	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))			*1 per arch for each authorized phase of orthodontic treatment; included in comprehensive case fee*	
D8681	Removable orthodontic retainer adjustment				
D8696	Repair of orthodontic appliance - maxillary			*1 per appliance; included in comprehensive case fee*	
D8697	Repair of orthodontic appliance - mandibular			*1 per appliance; included in comprehensive case fee*	
D8698	Re-cement or re-bond fixed retainer - maxillary			*1 per Contract Dentist; included in comprehensive case fee*	
D8699	Re-cement or re-bond fixed retainer - mandibular			*1 per Contract Dentist; included in comprehensive case fee*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D8701	Repair of fixed retainer, includes reattachment - maxillary			*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*	
D8702	Repair of fixed retainer, includes reattachment - mandibular			*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*	
D8703	Replacement of lost or broken retainer - maxillary			*1 per arch; within 24 months following the date of service for orthodontic retention (D8680)*	
D8704	Replacement of lost or broken retainer - mandibular			*1 per arch; within 24 months following the date of service for orthodontic retention (D8680)*	
D8999	Unspecified orthodontic procedure, by report			*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES					
D9110	Palliative treatment of dental pain - per visit	$30	$28	*1 per date of service per Contract Dentist; regardless of the number of teeth and/or areas treated*	
D9120	Fixed partial denture sectioning	$95	Not Covered		
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$10	Not Covered	*1 per date of service per Contract Dentist; for use to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state*	
D9211	Regional block anesthesia	$20	$20		
D9212	Trigeminal division block anesthesia	$60	$60		
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	$15		
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$45	$45		
D9222	Administration of deep sedation/general anesthesia - first 15 minute increment, or any portion thereof	$45	$45		1 per same day
D9223	Administration of deep sedation/general anesthesia - each subsequent 15 minute increment, or any portion thereof	$45	$45		3 per same day
D9224	Administration of general anesthesia with advanced airway - first 15 minute increment, or any portion thereof	$65	$65		1 per same day
D9225	Administration of general anesthesia with advanced airway - each subsequent 15 minute increment, or any portion thereof	$65	$65		3 per same day
D9230	Administration of nitrous oxide	$15	Not Covered	*(Where available)*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9239	Administration of moderate sedation - intravenous - first 15 minute increment, or any portion thereof	$60	$45	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*	1 per same day
D9243	Administration of moderate sedation - intravenous - each subsequent 15 minute increment, or any portion thereof	$60	$45	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*	3 per same day
D9244	In-office administration of minimal sedation - single drug - enteral	$30	Not Covered		
D9245	Administration of moderate sedation - enteral	$65	$65		1 per day
D9246	Administration of moderate sedation - non-intravenous parenteral - first 15 minute increment, or any portion thereof	$65	$65		1 per day
D9247	Administration of moderate sedation - non-intravenous parenteral - each subsequent 15 minute increment, or any portion thereof	$65	$65		1 per day
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50	$45		
D9311	Consultation with a medical health care professional	No charge	No charge		
D9410	House/extended care facility call	$50	Not Covered	*1 per Enrollee per date of service*	
D9420	Hospital or ambulatory surgical center call	$135	Not Covered		
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$20	$12	*1 per date of service per Contract Dentist*	
D9440	Office visit - after regularly scheduled hours	$45	$40	*1 per date of service per Contract Dentist*	
D9450	Case presentation, subsequent to detailed and extensive treatment planning	Not Covered	No charge		
D9610	Therapeutic parenteral drug, single administration	$30	Not Covered	*4 of (D9610, D9612) injections per date of service*	
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$40	Not Covered	*4 of (D9610, D9612) injections per date of service*	

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9910	Application of desensitizing medicament	$20	Not Covered	*1 per 12 months per Contract Dentist; permanent teeth*	
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$35	Not Covered	*1 per date of service per Contract Dentist within 30 days of an extraction*	
D9943	Occlusal guard adjustment	Not Covered	$35		*1 per 12 months (6 months after initial placement)*
D9944	Occlusal guard - hard appliance, full arch	Not Covered	$115		*1 of (D9944, D9945, D9946) per 3 years*
D9945	Occlusal guard - soft appliance, full arch	Not Covered	$115		*1 of (D9944, D9945, D9946) per 3 years*
D9946	Occlusal guard - hard appliance, partial arch	Not Covered	$115		*1 of (D9944, D9945, D9946) per 3 years*
D9950	Occlusion analysis - mounted case	$120	Not Covered	*Prior Authorization is required; 1 per 12 months for diagnosed TMJ dysfunction; permanent teeth; age 13+*	
D9951	Occlusal adjustment - limited	$45	$45	*1 per 12 months for quadrant per Contract Dentist; age 13+*	
D9952	Occlusal adjustment - complete	$210	$210	*1 per 12 months following occlusion analysis - mounted case (D9950) for diagnosed TMJ dysfunction; permanent teeth; age 13+*	
D9995	Teledentistry - synchronous; real-time encounter	No charge	No charge		
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No charge	No charge		
D9997	Dental case management - patients with special health care needs	No charge	No charge		

Code	Description	Pediatric Enrollee Pays	Adult Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees	Clarification/ Limitations for Adult Enrollees
D9999	Unspecified adjunctive procedure, by report	No charge	No charge	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

Endnotes:

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

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

Example of an Optional or upgraded procedure:

- If You chose an Optional or upgraded procedure presented by the Contract Dentist,
  - Where noble (D6061, D6064, D6071, D6074, D6083, D6087, D6099, D6122); high noble (precious) (D6059, D6062, D6066, D6067, D6069, D6072, D6076, D6077); or titanium (D6084, D6088, D6094, D6097, D6194, D6195, D6784) metals are used for an implant/abutment supported crown or fixed bridge retainer; and
  - An additional laboratory fee is charged by the Contract Dentist

Then You will be responsible for the fee charged by the laboratory which equals the difference between the higher cost of the Optional service and the lower cost of the customary service or standard procedure.

Additional Endnotes to Covered California's 2027 Dental Standard Benefit Plan Designs

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan or Family Dental Plan)

1. In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.

2. In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum.
3. Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment ("EPSDT") Benefit.
4. To the extent the dental plans can offer Teledentistry, it would be offered at no charge.
5. These Endnotes do not limit an Issuer's obligations to comply with applicable Federal, State, or local laws, rules, or regulations. In the event an Issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirements of these Endnotes, an Issuer shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these Endnotes exceed requirements imposed by law, an Issuer shall comply with the requirements in these Endnotes.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)

1. Tooth whitening, adult orthodontia, implants, veneers and adult services noted as Not Covered on the Copayment Schedule are not covered services.
2. To the extent the dental plans can offer Teledentistry, it would be offered at no charge.
3. These Endnotes do not limit an Issuer's obligations to comply with applicable Federal, State, or local laws, rules, or regulations. In the event an Issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirements of these Endnotes, an Issuer shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these Endnotes exceed requirements imposed by law, an Issuer shall comply with the requirements in these Endnotes.

SCHEDULE B
Limitations and Exclusions of Benefits

Delta Dental of California
Family Dental HMO

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

Limitations of Benefits for Adult Enrollees

1. The frequency of certain Benefits is limited. Frequency limitations are listed in *Schedule A, Description of Benefits and Copayments* ("Schedule A"). Additional requests, beyond the stated frequency limitations, for prophylaxis, fluoride and scaling procedures (D1110, D1120, D1206, D1208 and D4346) shall be considered for prior Authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $125 above the listed Copayment for each of these services after the sixth unit has been provided.
3. Administration of deep sedation/general anesthesia and/or administration of moderate sedation - intravenous - is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240 and D7241).
4. Local anesthesia and regional/or trigeminal block anesthesia are not separately payable procedures.
5. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan Benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed $325 in addition to the listed Copayment. Contact Delta Dental at 888-282-8528 if you have questions regarding the additional fee or name brand services.
6. Benefits for a soft tissue management program are limited to those parts which are listed covered services listed on *Schedule A*. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered Benefits.
7. Porcelain/ceramic crown, pontic and fixed bridge retainer on molars is considered a material upgrade with a maximum additional charge to the Enrollee of $150 per unit.

Exclusions of Benefits for Adult Enrollees

1. Any procedure that is not specifically listed as a covered Benefit under *Schedule A*.
2. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes.
4. Lost, stolen or broken appliances including, but not limited to, full or partial dentures, crowns, fixed partial dentures (bridges), orthodontic and other appliances.

5. Procedures, appliances or restoration if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings or to diagnose or treat abnormal conditions of the TMJ, with the exception of procedures as shown on *Schedule A*.
6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
8. Consultations or other diagnostic services for non-covered Benefits.
9. Dental services received from any dental facility other than the assigned Contract Dentist or an authorized Contract Specialist (oral surgeon, endodontist, periodontist, pediatric dentist) except for "Emergency Dental Services*"* or "Urgent Dental Services" as described in the EOC.
10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
11. Prescription and over-the-counter drugs.
12. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with this Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic Treatment in Progress provision.
13. Changes in orthodontic treatment necessitated by accident of any kind.
14. Myofunctional and parafunctional appliances and/or therapies, with the exception of as procedures shown on *Schedule A.*
15. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
16. Services or supplies for sleep apnea.
17. Administration of neuromodulators is not a Benefit of the plan.
18. Administration of dermal fillers is not a Benefit of the plan.
19. Photobiomodulation therapy.
20. Duplication of prosthetic device or appliance.

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

Limitations of Benefits for Pediatric Enrollees

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A.* Additional requests, beyond the stated frequency limitations, for prophylaxis, fluoride and scaling procedures shall be considered for prior Authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.
2. A filling (D2140-D2161, D2330-D2335, D2391-D2394) is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
3. A crown (D2390 and covered codes only between D2710-D2791) is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five+ year (60+ months) limitation.

4. The replacement of an existing crown (D2390 and covered codes only between D2710-D2791), fixed partial denture (bridge) (covered codes only between D6211-D6245, D6251, D6721-D6791) or a removable full (D5110, D5120) or partial denture (covered codes only between D5211-D5214, D5221-D5224) is covered when:

    a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, and
    b. Either of the following:
        - The existing non-functional restoration/bridge/denture was placed five or more years (60+ months) prior to its replacement, or
        - If an existing partial denture is less than five years old (60 months), but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.

5. Coverage for the placement of a fixed partial denture (bridge) (covered codes only between D6211-D6245, D6251, D6721-D6791) or removable partial denture (covered codes only between D5211-D5214, D5221-D5224):

    a. Fixed partial denture (bridge):
        - A fixed partial denture is a Benefit only when medical conditions or employment preclude the use of a removable partial denture.
        - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, or
        - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics, or
        - Each abutment tooth to be crowned meets Limitation #3.
    b. Removable partial denture:
        - Cast metal (D5213, D5214, D5223, D5224), one or more teeth are missing in an arch.
        - Resin based (D5211, D5212, D5221, D5222), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease.

6. Immediate dentures (D5130, D5140, D5221-D5224) are covered when one or more of the following conditions are present:

    a. extensive or rampant caries are exhibited in the radiographs, or
    b. severe periodontal involvement indicated, or
    c. numerous teeth are missing resulting in diminished chewing ability adversely affecting the Enrollee's health.

7. Maxillofacial prosthetic services (covered codes only between D5911-D5999) are for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.

8. All maxillofacial prosthetic procedures (covered codes only between D5911-D5999) require prior Authorization for medically necessary procedures.

9. Implant services (covered codes only between D6010-D6199) are a Benefit only under exceptional medical conditions. Exceptional medical conditions include, but are not limited to:

    a. cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prosthesis.
    b. severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures (D7340, D7350) or osseous augmentation procedures (D7950), and the Enrollee is unable to function with conventional prosthesis.

c. skeletal deformities that preclude the use of conventional prosthesis (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).

10. Temporomandibular joint dysfunction procedure codes (covered codes only between D7810-D7880) are limited to differential diagnosis and symptomatic care and require prior Authorization.
11. Certain listed procedures performed by a Contract Specialist may be considered to be primary under the Enrollee's medical coverage. Dental Benefits will be coordinated accordingly.
12. Administration of deep sedation/general anesthesia (D9222-D9225) or administration of moderate sedation - intravenous (D9239, D9243) for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.
13. 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 (D7259).

Exclusions of Benefits for Pediatric Enrollees

1. Any procedure that is not specifically listed under *Schedule A*, except as required by state or federal law.
2. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
3. Lost or theft of full or partial dentures (covered codes only between D5110, D5120, D5130, D5140, D5211-D5214, D5221, D5222, D5223, D5224), space maintainers (D1510-D1575), crowns (D2390 and covered codes only between D2710-D2791), fixed partial dentures (bridges) (covered codes only between D6211-D6245, D6251, D6721-D6791) or other appliances.
4. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
5. Dental expenses incurred in connection with any dental procedure before the Enrollee's eligibility in this Plan. Examples include: teeth prepared for crowns, partials and dentures, root canals in progress.
6. Dispensing of drugs not normally supplied in a dental facility unless included in Schedule A.
7. Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
   b. is inconsistent with generally accepted standards for dentistry.
8. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a Contract Specialist, unless expressly authorized or as cited under the “Emergency Dental Services” and “Urgent Dental Services” sections of the EOC. To obtain written Authorization, the Enrollee should call Delta Dental’s Customer Care at 888-282-8528.
9. Consultations (D9310, D9311) or other diagnostic services (covered codes only between D0120-D0999), for non-covered Benefits.
10. Single tooth implants (covered codes only between D6000–D6199).

11. Restorations (covered codes only between D2330-D2335, D2391-D2394, D2710-D2791, D6211-D6245, D6251, 6721-D6791) placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension.
12. Preventive (covered codes only between D1110-D1575), endodontic (covered codes only between D3110-D3999) or restorative (covered codes only between D2140-D2999) procedures are not a Benefit for teeth to be retained for overdentures.
13. Partial dentures (covered codes only between D5211-5214, D5221-D5224) are not a Benefit to replace missing 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for a partial denture with cast clasps or rests.
14. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth (covered codes only between D8000-D8999), periodontal splinting (D4322-D4323), gnathologic recordings, equilibration (D9952) or treatment of disturbances of the TMJ (covered codes only between D0310-D0322, D7810-D7899), unless included in *Schedule A*.
15. Porcelain denture teeth, or fixed partial dentures (overlays, implants, and appliances associated therewith) (D6940, D6950) and personalization and characterization of complete and partial dentures.
16. Extraction of teeth (D7111, D7140, D7210, D7220-D7240, D7241, D7250), when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars.
17. TMJ dysfunction treatment modalities that involve prosthodontia (D5110-D5224, D6211-D6245, D6251, D6721-D6791), orthodontia (covered codes only between D8000-D8999), and full or partial occlusal rehabilitation or TMJ dysfunction procedures (covered codes only between D0310-D0322, D7810-D7899) solely for the treatment of bruxism.
18. Vestibuloplasty/ridge extension procedures (D7340, D7350) performed on the same date of service as extractions (D7111-D7250) on the same arch.
19. Administration of deep sedation/general anesthesia (D9222-D9225) for covered procedures on the same date of service as administration of nitrous oxide or for administration of moderate sedation - intravenous (D9230, D9239, D9243).
20. Administration of moderate sedation - intravenous (D9239, D9243) for covered procedures on the same date of service as administration of nitrous oxide or for administration of deep sedation/general anesthesia (D9222-D9225).
21. Administration of nitrous oxide (D9230) when administered with other covered sedation procedures.
22. Cosmetic dental care (exclude covered codes in this list if done for purely cosmetic reasons: D2330-D2394, D2710-D2751, D2940, D6211-D6245, D6251, D6721-D6791, D8000-D8999).
23. Services or supplies for sleep apnea.
24. Administration of neuromodulators is not a Benefit of the plan.
25. Administration of dermal fillers is not a Benefit of the plan.

Medically Necessary Orthodontics for Pediatric Enrollees

1. Orthodontic Services are limited to the following automatic qualifying conditions:
    a. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior Authorization request,
    b. Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior Authorization request,

c. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
d. A crossbite of individual anterior teeth causing destruction of soft tissue,
e. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
f. Severe traumatic deviation.

2. The following documentation must be submitted with the request for prior Authorization of services by the Contract Orthodontist:

   a. ADA 2006 or newer claim form with service code(s) requested;
   b. Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
   c. Cephalometric radiographic image or panoramic radiographic image;
   d. HLD score sheet completed and signed by the Contract Orthodontist; and
   e. Treatment plan.

3. Coverage for comprehensive orthodontic treatment (D8080) requires acceptable documentation of a handicapping malocclusion as evidence by a minimum score of 26 points on the Handicapping Labio-Lingual Deviation ("HLD") Index California Modification Score Sheet Form and pre-treatment diagnostic casts (D0470). Comprehensive orthodontic treatment (D8080):

   a. is limited to Enrollees who are between 13 through 18 years of age with a permanent dentition without a cleft palate or craniofacial anomaly; but
   b. may start at birth for patients with a cleft palate or craniofacial anomaly.

4. Removable appliance therapy (D8210) or fixed appliance therapy (D8220) is limited to Enrollees between 6 to 12 years of age, once in a lifetime, to treat thumb sucking and/or tongue thrust.

5. The Benefit for a pre-orthodontic treatment examination (D8660) includes needed oral/facial photographic images (D0350, D0703, D0801, D0802, D0803, D0804). Neither the Enrollee nor the plan may be charged for D0350, D0703, D0801, D0802, D0803 or D0804 in conjunction with a pre-orthodontic treatment examination.

6. The number of covered periodic orthodontic treatment visits (D8670) and length of covered active orthodontics is limited to a maximum of up to:

   a. handicapping malocclusion - eight (8) quarterly visits;
   b. cleft palate or craniofacial anomaly - six (6) quarterly visits for treatment of primary dentition;
   c. cleft palate or craniofacial anomaly - eight (8) quarterly visits for treatment of mixed dentition; or
   d. cleft palate or craniofacial anomaly - ten (10) quarterly visits for treatment of permanent dentition.
   e. facial growth management - four (4) quarterly visits for treatment of primary dentition;
   f. facial growth management - five (5) quarterly visits for treatment of mixed dentition;
   g. facial growth management - eight (8) quarterly visits for treatment permanent dentition.

7. Orthodontic retention (D8680) is a separate Benefit after the completion of covered comprehensive orthodontic treatment (D8080) which:

   a. includes removal of appliances and the construction and place of retainer(s) (D8680); and
   b. is limited to Enrollees under age 19 and to one per arch after the completion of each phase of active treatment for retention of permanent dentition unless treatment was for a cleft palate or a craniofacial anomaly.

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

9. Copayment is payable to the Contract Orthodontist who initiates banding in a course of prior authorized orthodontic treatment (covered codes only between D8000-D8999). If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:

    a. will not be entitled to a refund of any amounts previously paid, and
    b. will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.

10. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment (covered codes only between D8000-D8999), the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

    If an Enrollee is receiving ongoing orthodontic treatment at the time of termination, Delta Dental will continue to provide orthodontic Benefits for:

    a. 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or
    b. until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

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

11. Orthodontics, including oral evaluations and all treatment, (covered codes only between D8000-D8999) must be performed by a licensed Dentist or their supervised staff, acting within the scope of applicable law.

12. The removal of fixed orthodontic appliances (D8680) for reasons other than completion of treatment is not a covered Benefit.

SCHEDULE C

Information Concerning Benefits Under The DeltaCare® USA Plan

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

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Annual Out-of-Pocket Maximum	Individual $350.00 Multiple Child $700.00
(D) Professional Services	An Enrollee may be required to pay a Copayment amount for each procedure as shown in *Schedule A, Schedule of Benefits and Copayments*, subject to the limitations and exclusions of the plan. Examples are as follows: Diagnostic Services No Charge Preventive Services No Charge Restorative Services $ 20.00 - $ 310.00 Endodontic Services $ 20.00 - $ 350.00 Periodontic Services $ 10.00 - $ 350.00 Prosthodontic Services (removable) $ 20.00 - $ 350.00 Maxillofacial Prosthetics $ 35.00 - $ 350.00 Implant Services (medically necessary only) $ 25.00 - $ 350.00 Prosthodontic Services (fixed) $ 20.00 - $ 350.00 Oral and Maxillofacial Surgery $ 30.00 - $ 350.00 Orthodontic Services (medically necessary only) $ 350.00 Adjunctive General Services No Charge - $ 210.00 **NOTE:** Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to one in a 6-month period.
(E) Outpatient Services	Not Covered
(F) Hospitalization Services	Not Covered
(G) Emergency Dental Coverage	Benefits for Emergency Dental Services by an Out-of-Network Dentist are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.
(H) Ambulance Services	Not Covered
(I) Prescription Drug Services	Not Covered
(J) Durable Medical Equipment	Not Covered
(K) Mental Health Services	Not Covered
(L) Chemical Dependency Services	Not Covered
(M) Home Health Services	Not Covered
(N) Other	Not Covered

Each individual procedure within each category listed above, and that is covered under the plan, has a specific Copayment that is shown in *Schedule A, Description of Benefits and Copayments* in the EOC.

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, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Please call 888-282-8528 (TTY: 711).

¿Puede leer este documento? Si no es así, tiene a su disposición servicios gratuitos de asistencia lingüística. También se ofrecen sin cargo ayudas y servicios auxiliares adecuados para proveer información en formatos accesibles. Llame 888-282-8528 (servicio de retransmisión TTY deben llamar al 711). (Spanish)

您能否读懂这份文件？如果不能，我们可为您提供免费的语言协助服务。同时也免费提供适当的辅助用具和服务，以提供无障碍格式的信息。敬请来电 888-282-8528 (TTY: 711)。(Chinese)

Kaya mo bang basahin ang dokumentong ito? Kung hindi, may mga magagamit kang libreng serbisyo para sa tulong sa wika. Mayroon ding mga libreng naaangkop na auxiliary aid at serbisyo para magbigay ng impormasyon sa mga accessible na format. Mangyaring tumawag 888-282-8528 (TTY: 711). (Tagalog)

Quý vị có đọc được tài liệu này không? Nếu không, quý vị có thể sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí. Các dịch vụ và hỗ trợ bổ sung thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi điện 888-282-8528 (TTY: 711). (Vietnamese)

이 문서를 읽을 수 있습니까? 그렇지 않은 경우, 무료 언어 지원 서비스를 이용할 수 있습니다. 정보를 이해할 수 있는 형식으로 제공하기 위한 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 888-282-8528 (TTY: 711) 번으로 전화해 주십시오. (Korean)

Կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, ապա Ձեզ հասանելի են անվճար լեզվական օգնության ծառայություններ: Մատչելի ձևաչափերով տեղեկատվություն տրամադրելու համար համապատասխան օժանդակ միջոցներն ու ծառայությունները նույնպես հասանելի են անվճար: Խնդրում եմ զանգահարել 888-282-8528 (TTY՝ 711): (Armenian)

می‌توانید این سند را بخوانید؟ اگر نمی‌توانید، خدمات کمک زبانی به‌صورت رایگان در دسترس شما قرار دارد. امکانات و خدمات کمکی مناسب برای ارائه اطلاعات در قالب‌های دسترسی‌پذیر نیز به‌صورت رایگان در اختیارتان قرار دارد. لطفاً تماس بگیرید 888-282-8528 (TTY: 711). (Persian Farsi)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع قراءته، فإنه تتوفر لك خدمات مساعدة لغوية مجانية. تتوفر مجانًا أيضًا خدمات ووسائل مساعدة مناسبة لتقديم المعلومات بتنسيقات ملائمة لذوي الاحتياجات الخاصة. يرجى الاتصال هاتفيًا 888-282-8528 (TTY: 711). (Arabic)

Можете ли вы прочитать этот документ? Если нет, воспользуйтесь бесплатными услугами языковой поддержки. Кроме того, предусмотрены бесплатные вспомогательные средства и услуги по предоставлению информации в доступных форматах. Позвоните 888-282-8528 (телетайп: 711). (Russian)

क्या आप यह दस्तावेज़ पढ़ सकते हैं? यदि नहीं तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। सुलभ प्रारूपों में जानकारी उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। कृपया कॉल करें 888-282-8528 (TTY: 711)। (Hindi)

本書類が読めますか？読めない場合は、無料の言語支援サービスをご利用ください。利用しやすいフォーマットで情報を提供するための適切な補助具やサービスも、無料でご利用いただけます。お電話でお問い合わせください 888-282-8528 (TTY: 711).(Japanese)

ਕੀ ਤੁਸੀਂ ਇਹ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਸੁਵਿਧਾਜਨਕ ਫਾਰਮੈਟ ਵਿੱਚ ਜਾਣਕਾਰੀ ਦੇਣ ਲਈ ਉਚਿਤ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ ਕਾਲ ਕਰੋ 888-282-8528 (TTY: 711)। (Punjabi)

Koj nyeem puas tau daim ntaub ntawv no? Yog tias tsis tau no, ces yuav muaj kev pab cuam txhais lus pab dawb rau koj. Cov khoom pab thiab cov kev pab cuam ntxiv uas tsim nyog los muab ntaub ntawv qhia paub ua hom ntaub ntawv uas siv tau kuj yuav muaj yam tsis tsub nqi dab tsi ntxiv. Thov hu rau 888-282-8528 (TTY: 711). (Hmong)

តើ អ្នកអាចអានឯកសារនេះបានទេ? ប្រសិ នបើ មិ នបានទេ សេវាជំនួយផ្នែកភាសាឥតគិ តថ្លៃអាចរកបានសម្រាប់អ្នក។ ជំនួយ និ ងសេវា ជំនួយដែលសមស្របដើ ម្បី ផ្តល់ព័ ត៌ មានក្នុងទម្រង់ដែលអាចងាយប្រើ បាន ក៏ អាចរកបានដោយឥតគិ តថ្លៃផងដែរ។ សូមហៅទូរសព្ទទៅ 888-282-8528 (TTY` 711)។ (Cambodian)

คุณสามารถอ่านเอกสารนี้ได้หรือไม่ หากไม่สามารถอ่านได้ บริการช่วยเหลือด้านภาษาโดยไม่มีค่าใช้จ่ายพร้อมให้บริการ นอกจากนี้ ยังมีอุปกรณ์ช่วยเหลือและบริการเสริมที่เหมาะสมโดยไม่เสียค่าใช้จ่าย เพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้ กรุณาติดต่อ 888-282-8528 (TTY: 711) (Thai)

Èske ou ka li dokiman sa a? Si w pa kapab, gen sèvis asistans lengwistik gratis ki disponib pou ou. Gen èd ak sèvis oksilyè ki apwopriye pou bay enfòmasyon nan fòma aksesib ki disponib tou gratis. Tanpri rele 888-282-8528 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document? Autrement, une service gratuit d’assistance linguistique est à votre disposition. Vous pouvez aussi disposer gratuitement d’aides et de services auxiliaires pour que les informations soient fournies sous des formats accessibles. Veuillez appeler 888-282-8528 (TTY: 711). (French)

Jesteś w stanie przeczytać ten dokument? Jeśli nie, możesz skorzystać za darmo z bezpłatnych usług pomocy językowej. Odpowiednie pomoce dodatkowe i usługi zapewniające dostarczanie informacji w formatach dla osób ze specjalnymi potrzebami są również dostępne bezpłatnie. Prosimy o kontakt telefoniczny 888-282-8528 (TTY: 711). (Polish)

Consegue ler este documento? Caso contrário, estão disponíveis para si serviços de assistência linguística gratuitos. Estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue-nos 888-282-8528 (TTY: 711). (Portuguese)

Riesci a leggere questo documento? In caso contrario, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi accessori per fornire informazioni in formati accessibili. Chiama 888-282-8528 (TTY: 711). (Italian)

Können Sie dieses Dokument lesen? Falls nicht, stehen Ihnen kostenlose Sprachhilfe-Dienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in barrierefreien Formaten sind ebenfalls kostenlos verfügbar. Bitte rufen Sie an 888-282-8528 (Schreibtelefon: 711). (German)

צי קענט איר לייענען די דאקומענט? אויב נישט, זענען דא אומזיסטע שפראך הילף סערוויסעס פאר אייך צו באקומען. נאך הילפס מיטלען און סערוויסעס אייך צו גיבן אינפארמאציע אין א פארמאט וואס ארבעט פאר אייך ווערן אויך צוגעשטעלט. ביטע רופט 888-282-8528 (TTY) 711 (Yiddish)

Díí naaltsoos baa nitsáháskeesgo shił yá’áhoot’é? Doo shił łahgo át’é da, t’áá ánooldó’ tł’óó’ baa áháni bik’i’diilyaago baa nitsáhákeesgo at’é. Ákót’éego bee áháyá t’áá ałtso bá hólónígíí dóó yá’át’éehígíí bee náníká be’elya, dóó t’áá ánooldó’ bila’ ashłí. T’áá shą́ naaltsoos bikáá’ ách’į’ haasdzíí dooleeł 888-282-8528 (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).