DeltaCare® USA Network Access Plan
September 2025

Administered by Delta Dental Insurance Company and
underwritten by Dentegra Insurance Company.

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INTRODUCTION

Administrator: Delta Dental Insurance Company

Underwriter: Dentegra Insurance Company

Network: DeltaCare USA

Network ID: DENT001

Website: **deltadentalins.com**

Customer Service 800-422-4234

At Delta Dental[1], we seek to provide our subscribers with access to the best dental care possible at a reasonable cost to fulfill our mission, to improve the oral health of the communities we serve. The DeltaCare® USA network has participating providers in all specialties in nearly every community across the state of Colorado. The Access Plan set forth below describes the process by which Delta Dental ensures that its members have sufficient access to quality care through the provider network.

DEFINITIONS

General Dentist: a primary care provider who is skilled in and licensed to practice dentistry for patients in all age groups and is responsible for the diagnosis, treatment, management, and overall coordination of services to meet the patient's oral health needs.

Specialist: a licensed provider in dentistry who has obtained additional education and/or certification to practice specialized treatment such as Pediatric, Oral Surgeon, Endodontics, Periodontics, Prosthodontics, and Orthodontics for patients in all age groups.

Independent Dental Hygienist: a hygienist licensed to independently provide authorized dental services.

Essential Community Provider: a provider who demonstrates a commitment to serve low-income and medically indigent populations that make up a significant portion of the Essential Community Provider patient population or, in the case of a sole community provider, serve the medically indigent patients within its medical capability. It is DIC's policy to contract with any ECP that meets quality and credentialing standards. Of note, ECPs are included in all of the above categories.

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

Copayment: copayments are the amount Enrollees are responsible for paying at the time treatment is received.

Contract Dentist as appropriate: Dentists who have agreed to provide services, either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services. Referrals for Specialist.

Services must be obtained from an Enrollee's DeltaCare USA Dentist who is responsible for the Enrollee's primary dental care and referrals for Specialty Services.

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

[1] Although Dentegra Insurance Company ("DIC") underwrites the DeltaCare USA plans, Delta Dental Insurance Company ("Delta Dental" or "DDIC") is the administrator, and handles all administrative aspects of the DeltaCare USA plans and its provider network.

Emergency/Urgent Care: dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing Enrollees in serious jeopardy. Emergent/Urgent dental care is limited to palliative treatment for the elimination of dental pain.

Enrollee: an individual eligible to receive benefits under a group plan or individual policy. Non-DeltaCare USA Dentist or Non-participating Dentist ("Non-DeltaCare USA Dentist"): a Dentist who has not signed a contract with Us to provide benefits as DeltaCare USA Dentist or is not contractually bound to abide by Our administrative guidelines.

Specialist Services: Services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics, or pediatric dentistry. Specialist Services must be referred by the Enrollee's DeltaCare USA Dentist.

County Types

County Type	Population	Density
Large Metro	l,000,000	.,000/sq. mile
	500,000 - 999,999	l,500/sq. mile
	Any	5,000/sq. mile
Metro	l,000,000	10 - 999.9/sq. mile
	500,000 - 999,999	10 - 1,499.9/sq. mile
	200,000 - 499,999	10 - 4,999.9/sq. mile
	50,000 - 199,999	100 - 4,999.9/sq. mile
	10,000 - 49,999	1,000 - 4,999.9/sq. mile
Micro	50,000 - 199,999	10 - 99.9/sq. mile
	10,000 - 49,999	50 - 999.9/sq. mile
Rural	10,000 - 49,999	10 - 49.9/sq. mile
	<10,000	10 - 4,999.9/sq. mile
CEAC	Any	<10/sq. mile

NETWORK ADEQUACY

We strive to maintain a comprehensive array of providers within our network sufficient to serve the dental needs of subscribers throughout Colorado, regardless of the enrollee's dental need, location, or cultural characteristics. To do so, we regularly and systematically monitor the DeltaCare USA network to determine the adequacy of the network to ensure it meets member dental needs. Such monitoring includes, but is not limited to, the following: Periodic Geo Access reports are also generated as needed. Periodic reports are used to document and track issues until resolved as needed or required.

Enrollment and network numbers are compared monthly to determine any access to care deficits within the service area. If an access to care deficit is identified, a meeting is held to ascertain the recruitment steps necessary to address the deficit.

While our service area covers the entire state of Colorado, there could be counties where there are no in-network providers. If an enrollee does not have access to a dentist within the distance standards, we will locate a non-network provider that meets the enrollee's needs. There are currently six inadequate counties. Those counties are Alamosa, Kit Carson, Logan, Prowers, Rio Grande and

Routte. We ensure that the enrollee pays only the enrollee coinsurance to the non-network provider. In this instance, we will advance payment arrangement with the non-network provider ensures that the enrollee is not balance billed, and the enrollee is not held responsible to pay any amount that exceeds payment to the non-network provider.

The DeltaCare USA network currently contracts with the following participating providers:

- 440 general dentists at 161 locations
- 112 specialists at 113 locations (Endodontics, Oral Surgery, Orthopedics, Pediatric, Periodontics, and Prosthodontics)

The DeltaCare USA Network Adequacy Standards

Geographic Type					
Provider type - plan provides access to at least one dental provider for at least 90% of the enrollees	**Large Metro**	**Metro**	**Micro**	**Rural**	**CEAC**
	Maximum Road Travel Distance (miles)	Maximum Road Travel Distance (miles)	Maximum Road Travel Distance (miles)	Maximum Road Travel Distance (miles)	Maximum Road Travel Distance (miles)
Dentist	15	30	60	75	110

Our goal is to provide access to care to the extent such services are relatively available based on location, number and types of dental providers available, cost and quality of care, credentialing requirements and considering usual travel patterns within the community. We are willing to contract with all licensed dental providers that meet the credentialing and participation requirements identified at **www.deltadentalins.com** on the Provider page.

	Large Metro	**Metro**	**Micro**	**Rural**	**CEAC**
General	100%	100%	100%	97.1%	93.3%
Pediatric	100%	99.9%	96.4%	99.9%	94.4%
Endodontics	100%	100%	83.9%	88.2%	83.9%
Periodontics	100%	99.5%	89.2%	89.5%	72.2%
Oral Surgery	100%	100%	83.9%	88.2%	66.7%
Orthodontics	100%	99.9%	90.3%	79.4%	90.3%

All participating DeltaCare USA providers have a contract that provides financial protection for our subscribers. A provider may not balance bill our subscribers for covered services. They must adhere to the DeltaCare USA fee schedule set forth by DDIC.

NETWORK MONITORING

The Network Access and Adequacy Monitoring Committee (NAAMC) has oversight responsibility to ensure adequate and accessible networks for enrollees. The Committee monitors provider network internal access and adequacy standards, in addition to external network regulatory requirements for all networks.

Resources

The Company's senior leadership ensures the availability of staff and financial resources to support the function of the Committee. The Committee also utilizes the services of the Company's legal counsel and other advisors to the Company.

Teledentistry
We provide the same benefit for covered services whether Enrollees see a DeltaCare USA provider in a dental office setting or consult via Teledentistry. We do not use out of network Teledentistry Dentists to supplement Our networks.

CORRECTIVE ACTION PROCESSES

As part of our ongoing NCQA certification requirements and standards, Delta Dental conducts monthly monitoring of our network providers for license actions, sanctions, etc. If a provider has a licensing or other action that falls outside our company's credentialing and contracting guidelines, we send a termination notification letter to the provider. The provider is then terminated from participating in our network.

We routinely audit providers every 3 years for license, DEA and malpractice actions to ensure the provider continues to be in good standing. Providers must also comply with the responsibilities and obligations set forth in the DeltaCare USA Contract Dentist Agreement or Delta Dental Practice Agreement and Delta Dental DeltaCare USA Network Attachment, as applicable, including disclosures and credentialing requirements. If the provider fails to recredential with us in a timely manner, we send a certified termination notification letter to the provider, and then terminate the provider from the network.

As noted in the Enrollee Notification of DeltaCare USA Provider Terminations Policy: We notify all enrollees that have received treatment from the terminated provider in the prior 6 months, via mail or other requested method of notification, to advise of the provider's termination from the network. The enrollee notice contains information to request continuation of treatment and care.

Corrective Action – Referrals; Prior Authorization for PPACA Pediatric Medically Necessary Orthodontic Services: Referrals are not required. Prior authorization is required for medically necessary pediatric orthodontic services under PPACA pediatric plans. If the provider fails to obtain prior authorization of medically necessary pediatric orthodontic services, the claims will be denied. In addition, a Delta Dental representative would reach out to the provider office to educate and/or assist in submitting information needed for processing.

Corrective Action Plans typically include assignment of Continuing Education courses in applicable areas and remedy of the deficiency within an assigned time period for the provider/facility to remain a member in good standing.

In most cases, member dentists and facilities will be given the opportunity to correct any deficient areas. However, when a deficiency finding puts enrollees at risk of imminent danger or falls below standards of care to an extent that creates a known risk to patient safety, as defined solely by the Peer Review Committee, Delta Dental may take immediate action to suppress a member dentist in the network, suspend or terminate a member contract, or take other action as deemed necessary by Delta Dental to protect enrollees.

In the event a provider suddenly closes their office, a member can reach out to customer services for assistance in locating another provider.

PROCEDURES FOR REFERRAL PROCESS

Enrollee plan documents include information about how Enrollees may select and change their DeltaCare USA Dentist. Enrollees should contact Our Customer Service Center at 877-522-9156 to select another DeltaCare USA Dentist. We will ask Enrollees to select another Dentist when the DeltaCare USA Dentist is no longer accepting new patients, no longer participates in the DeltaCare USA plan, or when requesting a change for good cause. We do ask Enrollees to complete any dental treatment in progress before changing Dentists.

To locate a DeltaCare USA Dentist, Enrollees may access Dentist participation information by visiting Our Dentist directory available through Our website at deltadentalins.com and selecting the Find A Dentist feature or by contacting Our Customer Service Center at 877-522-9156. A disclosure in the Dentist directory informs Enrollees that it is updated every business day with updated listings appearing each week Tuesday through Saturday.

PLAN FEATURES

Enrollee plan documents contain information regarding the Enrollee's network options, schedules of benefits and copayments, and limitations and exclusions applicable to their plan benefits. Any preventive care services offered are described in the Enrollee's plan documents (e.g., Evidence of Coverage). Preventive dental services are not a mandated benefit in Colorado.

All services received from DeltaCare USA Dentists are subject to Enrollee Copayments due at the time of service, any deductibles, annual maximums and waiting periods, and services not covered by the Enrollee's plan. If there is not a DeltaCare USA Dentist available, in accordance with Our Network Adequacy Exception, we will treat the services as in-network and Enrollees will be responsible for any applicable Copayment.

EMERGENCY/URGENT CARE

Enrollee plan documents inform Enrollees with a dental emergency that they should contact their DeltaCare USA Dentist whenever possible. Our DeltaCare USA Dentists maintain a twenty-four (24) hour Emergency Care system seven (7) days a week. If Enrollees are unable to reach their DeltaCare USA Dentist for Emergent/Urgent Care, they should contact Our Customer Service Center at 877-522-9156 for assistance.

Enrollees may seek Emergent/Urgent care from a Dentist other than a DeltaCare USA Dentist with no referral during non-business hours or when Emergent/Urgent Services are more than thirty-five (35) or more miles from the Enrollee's DeltaCare USA Dentist. Benefits provided for Emergent/Urgent Care not provided by a DeltaCare USA Dentist may be limited to the Enrollee's plan's Emergency Services maximum amount less the Copayment, if applicable.

SPECIALTY CARE

Enrollee plan documents explain Specialist Services for oral surgery, endodontics, orthodontics, periodontics, or pediatric dentistry must be referred by the DeltaCare USA Dentist.

If Specialist Services are required and there is no DeltaCare USA Dentist or Dentist specialist to provide these services within reasonable proximity of the Enrollee's home, Enrollees must receive Authorization from Us to receive services from a Non-DeltaCare USA Dentist specialist. Specialist Services performed by a Non-DeltaCare USA Dentist specialist that are not authorized by Us are not covered.

COMMUNICATIONS

We recognize the cultural, racial, and ethnic diversity of Our Enrollees. Since a diverse population may also have different language needs, vital documents and significant communications are translated into non-English languages to facilitate communication regardless of the Enrollee's medical condition whether serious, chronic, or complex to facilitate the following:

- Communicate their dental needs to Dentists using face-to face interpretative services (e.g., sign language, large print, audio, and accessible electronic formats)
- Understand plan documents and Enrollee communications by providing free documentation translation services, including:

- Our deltadentalins.com web portal displays multiple links to Language Assistance Program (“LAP”) information.
- We provide a LAP notice in multiple languages in all plan documents and on Our website Our Find a Dentist website portal at deltadentalins.com includes a convenient link to the LAP notice and is available in multiple languages

• Enhance Dentist-chair LAP experiences by DeltaCare USA Dentists who have self-reported they or their staff speak languages other than English and can assist with language assistance. Self-reported language information is displayed on the Find a Dentist on-line directory available at deltadentalins.com.

Our language assistance program (“LAP”) notice is attached to Enrollee plan documents and is available online at deltadentalins.com landing page and conveniently located on our Find a Dentist online dentist directory portal page. Additionally, the deltadentalins.com landing page includes a disclosure under About Delta Dental – Language Assistance that provides Enrollees with a listing of available LAP services. Language assistance interpretive services are also available for documents distributed to Enrollees, for Enrollee calls to Our Customer Service Center at 877-522-9156 and during visits to dental offices.

We also provide free aids and services to people with disabilities to communicate effectively with Us, such as qualified sign language interpreters and written information in other formats (e.g., sign language, large print, audio, and accessible electronic formats).

We aim to foster cultural competency among Our Dentists by promoting effective Dentist/Enrollee communications. We create educational materials for Dentists and incorporate these into Our Dentist training presentations. Our Dentist directory includes language spoken by Our Dentists or their staff in the dental office. Because We acknowledge the importance of communication between the Enrollee and Dentist, Dentists are asked to self-report languages spoken in the office; however, we do not certify the Dentist’s proficiency in reported languages. Written notification of changes to Dentist office languages are updated and published on Our online Dentist directory. Updates are made Monday through Friday and published Tuesday through Saturday.

ENROLLEE SATISFACTION

We regularly assess Enrollee satisfaction with the plan, Our Dentists, benefits, and plan operations. We send satisfaction surveys to randomly selected Enrollees on a quarterly basis and record and assess the results to build programs and action plans to address any identified issues. To preserve confidentiality, individual Enrollees are not identified in any Enrollee satisfaction report. We assess Enrollee satisfaction in the following categories: The quality of care received The information the dental office gave the Enrollee concerning needed treatment and its cost Appointment availability at the dental office: Office wait-times The appearance, cleanliness, and maintenance of the dental office Wheelchair access or other needed accommodations The current network Dentist, overall The range of dental benefits available to the Enrollee Service from Our Customer Service Center Printed Enrollee materials furnished by Us The choice of Dentists available to the Enrollee.

NETWORK ACCESS PLAN DISCLOSURES

We disclose to Enrollees, through enrollment materials, our website deltadentalins.com, Enrollee communications, and plan documents (Evidence of Coverage for Enrollees covered under a group plan, or Policy for Enrollees who purchased individual coverage), and by contacting Our Customer Service Center at 877-522-9156.

GRIEVANCE AND APPEAL PROCEDURES

The ability to file grievances and appeals from adverse benefit determinations constitutes an important element in an insured's access to care. Without the right to appeal, a member might not be able to avail the benefits to which they are rightfully entitled. Delta Dental has thorough processes in place for evaluating grievances, complaints, and appeals. Such processes are described below in more detail.

Delta Dental will, upon written request from the Member or treating provider on behalf of the Member, re-evaluate benefit determinations when appropriate. The review will be premised on the submission of additional information, documentation, or narrative, by the treating provider, which could affect the benefit determination previously made, according to the terms of the benefit plan, clinical review, Delta Dental's processing policies and/or the provider handbook.

QUALITY OF CARE GRIEVANCE

We will notify the Enrollee 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 claims, our policies, procedures or operations or the quality of dental services performed by a DeltaCare USA Dentist, you may call Customer Care at 877-522-9156 or mail Your complaint to:

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

Written communication must include: 1) the patient's name, 2) the Primary Enrollee's name, address, telephone number and ID number and 3) the treating Dentist Facility Name and Number.

"Grievance" means a written or verbal 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 the Enrollee or the 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 the Enrollee, a representative designated by the Enrollee or other individual with authority to act on behalf of the Enrollee.

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 and 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 contact Our Customer Care at 877-522-9156 and/or visit our website at **deltadentalins.com** to obtain a grievance form.

COMPLAINTS INVOLVING AN ADVERSE BENEFIT DETERMINATION

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim), You, your authorized representative or any in-network Dentist acting on Your behalf must file a request for review (a complaint) with Delta Dental within at least 180 days after receipt of the adverse determination. Our review will consider all information, regardless of whether such information was submitted or considered initially. The review will be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual.

Upon request and free of charge, we will provide You with copies of any pertinent documents that are relevant to the benefit determination and with a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the 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 the Contract, we will consult a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 days of the receipt of any complaint, including adverse benefit determinations as described above, a quality management coordinator will send you an acknowledgment of receipt of the complaint. Certain complaints may require that You be referred to a Dentist for a clinical evaluation of the dental services provided. We will make a determination, in writing, within [30 days] of receipt of a complaint or shall provide a written explanation if additional time is required to report on the complaint.

APPEAL OF DETERMINATION

A review of the decision will be undertaken if a written request for an appeal of the determination is made within 30 days of the date of the written determination. We shall undertake a full and fair review upon request. We may require additional documents as we deem necessary in making such a review. We will provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results. If you believe you need further review of your claim and/or your grievance, you may contact your state insurance regulatory agency.

COORDINATION AND CONTINUITY OF CARE

When a member is covered under two separate insurance policies for the same procedure or procedures, Delta Dental and its DeltaCare USA network providers coordinate benefits provided under group plans in accordance with Colorado law as set forth in Colorado Division of Insurance Regulation 4-6-2 and C.R.S. § 10-16-704.

When members activate or terminate dental coverage with DIC, they may have to change providers. In certain circumstances, DIC provides coverage for continuing care that was in progress before a new member’s effective date with DIC. Benefits may also be allowed if the DeltaCare USA network experiences significant disruption due to provider contract terminations.

When members switch coverage between one DeltaCare USA network provider and another, Delta Dental advises which provider is permitted to bill a patient for services. DeltaCare USA network providers are aware of the dates upon which they are permitted to bill for services, and the amounts they are permitted to collect from Delta Dental and/or the patient for services not completed. The clarity Delta Dental provides related to these transitional situations leads to greater access to affordable dental care by not subjecting the member to uncertainty or even double payment that might arise with other carriers.

When benefits end while a member still needs care, Delta Dental ensures that the member receives an Explanation of Benefits indicating that his or her benefits have been exhausted. As long as the member remains eligible and his/her plan remains in place, Delta Dental continues to enforce terms of its DeltaCare USA schedule of allowances upon DeltaCare USA dentists who are in-network with DIC in Colorado. By doing so, Delta Dental ensures that its members who receive services from DeltaCare USA dentists receive the beneficial pricing that comes with having a DIC insurance plan.

DIC members also have access to Patient Benefit Reports, either through the website at **www.deltadentalins.com** or through its automated telephone system. These reports allow members to be aware of the benefits remaining on his or her plan when changing dentists. DIC customer

experience representatives are also able to educate the member about alternatives for continuing care and, as appropriate, how to obtain care after benefits have ended or been exhausted. The participating provider agreements signed by DeltaCare USA network providers make it clear that, in the event of insolvency of DeltaCare USA network providers are not permitted to bill the member for the balance of any bill that is the responsibility of DIC.

When a participating provider terminates from the network, members are notified via mail 45 days prior to the date of termination. The participating provider agreements require either party to provide 60-day notice to the other party, and also require Dentegra Insurance Company and the provider to allow the covered persons to continue receiving care, which will be covered by Dentegra Insurance Company pursuant to the covered person's contract for 60 days from the date a participating provider is terminated by DeltaCare USA without cause when proper notice has not been provided to the covered persons.

Hold Harmless

Enrollee is responsible for the copayment, deductible and coinsurance applicable to his or her benefit Plan. Practice agrees to accept payments from Delta Dental, an Affiliate, or a Member Company, plus the Enrollee payments under the Plan, as payment in full for Plan Services and to not seek any surcharge or other additional payment from an Enrollee, whether or not payment is received from Delta Dental, an Affiliate, or a Member Company. Whenever Delta Dental, an Affiliate, or a Member Company receives notice of a surcharge, it shall take appropriate action, including but not limited to recouping the appropriate amounts from future payments to Practice, and/or terminating this Agreement. Neither Enrollees nor a Plan's sponsoring entity shall be liable to Practice or any Participating Provider for any sums owed to Practice by Delta Dental, an Affiliate, or a Member Company. Practice shall charge and make reasonable efforts to collect the entire amount payable by the Enrollee, under the terms of the Enrollee's Plan. Amounts determined to be an Enrollee's payment obligation shall not be waived, reduced or rebated. Practice shall cooperate with Delta Dental in the proper collection of third-party payments including coordination with other coverage, workers' compensation, third-party liens and other third-party liabilities. Practice agrees to disclose any other insurance for which the Enrollee is also eligible on any claims submitted to Delta Dental. Furthermore, if Delta Dental is secondary, Practice agrees to provide the explanation of benefits provided by the carrier that adjudicated the claim as the primary payer.