DeltaCare® USA

Dental Health Care Program for Eligible
Employees and Dependents

Combined Evidence of Coverage and Disclosure Form

CAA19

Provided by:
Delta Dental of California
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703

Administered by:
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023
800-422-4234

deltadentalins.com

EVIDENCE OF COVERAGE

DISCLOSURE FORM

DeltaCare® USA Dental HMO Program

This booklet is a Combined Evidence of Coverage and Disclosure Form ("EOC") for your DeltaCare USA Dental HMO Program ("Program") provided by Delta Dental of California ("Delta Dental"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Delta Dental.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. AS REQUIRED BY THE CALIFORNIA HEALTH & SAFETY CODE, THIS IS TO ADVISE YOU THAT THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY. PERSONS WITH SPECIAL HEALTHCARE NEEDS SHOULD READ THE SECTION ENTITLED "SPECIAL NEEDS".

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

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a Contract Dentist may charge you his or her 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 Service at 800-422-4234 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

The telephone number where you may obtain information about Benefits is 800-422-4234.

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM AND THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Professional Services	An Enrollee may be required to pay a Copayment amount for each procedure as shown in the *Description of Benefits and Copayments*, subject to the limitations and exclusions. Copayments range by category of service. Examples are as follows: Diagnostic Services — No Cost Preventive Services — No Cost - $ 15.00 Restorative Services — No Cost - $ 60.00 Endodontic Services — No Cost - $ 105.00 Periodontic Services — No Cost - $ 150.00 Prosthodontic Services — No Cost - $ 135.00 Oral and Maxillofacial Surgery — No Cost - $ 40.00 Orthodontic Services — No Cost - $1,800.00 Adjunctive General Services — No Cost - $ 20.00 **NOTE:** Some services may not be covered. Certain services may be covered only if provided by specified Dentists, or may be subject to an additional charge. Limitations apply to the frequency with which some services may be obtained. For example: bitewing x-rays are limited to one series of four films in each six month period; replacement of complete dentures, crowns and bridges is limited to once in any five year period.
(D) Outpatient Services	Not Covered
(E) Hospitalization Services	Not Covered
(F) Emergency Dental Coverage	The Enrollee may receive a maximum Benefit of up to $100 per emergency for out-of-area Emergency Services.
(G) Ambulance Services	Not Covered
(H) Prescription Drug Services	Not Covered
(I) Durable Medical Equipment	Not Covered
(J) Mental Health Services	Not Covered
(K) Chemical Dependency Services	Not Covered
(L) Home Health Services	Not Covered
(M) Other	Not Covered

Each individual procedure within each category listed above, and which is covered under the Program has a specific Copayment, which is shown in the *Description of Benefits and Copayments*, in the Combined Evidence of Coverage and Disclosure Form.

Table Of Contents

Definitions..... 1

Eligibility for Benefits..... 2

Prepayment Fees/Premiums..... 3

How to use the DeltaCare USA Plan - Choice of Contract Dentist..... 4

Continuity of Care..... 4

Special Needs..... 5

Facility Accessibility..... 5

Benefits, Limitations and Exclusions..... 5

Copayments and Other Charges..... 5

Emergency Services..... 5

Specialist Services..... 6

Second Opinion..... 6

Claims for Reimbursement..... 7

Provider Compensation..... 7

Processing Policies..... 7

Coordination of Benefits..... 7

Enrollee Complaint Procedure..... 8

Public Policy Participation by Enrollees..... 9

Renewal and Termination of Benefits..... 10

Cancellation of Enrollment..... 10

Optional Continuation of Coverage (COBRA)..... 10

Organ and Tissue Donation..... 14

Description of Benefits and Copayments..... 15

Limitations of Benefits..... 27

Exclusions of Benefits..... 30

Orthodontic Limitations..... 32

Orthodontic Exclusions..... 34

Accident Injury Benefit..... 35

Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company, a third party entity designated to perform administrative functions described throughout the Contract, including, but not limited to, the collection of Premium and eligibility.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

Eligible Employee means any employee or group member who is eligible for Benefits as described in this booklet.

Emergency Service means care provided by a Dentist to treat a dental condition which manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the Enrollee to result in either: (i) placing the Enrollee's dental health in serious jeopardy, or (ii) serious impairment to dental functions.

Enrollee means an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Out-of-Network means treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits under this Program.

Preauthorization means the process by which Delta Dental determines if a procedure or treatment is a referable covered Benefit under the Enrollee's plan.

Reasonable means that an Enrollee exercises prudent judgment in determining that a dental emergency exists and makes at least one attempt to contact his/her Contract Dentist to obtain Emergency Services and, in the event the Dentist is not available, makes at least one attempt to contact Delta Dental for assistance before seeking care from another Dentist.

Special Health Care Need means 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 the assigned Contract Dentist's facility because of a physical disability and 2) the Enrollee's inability to comply with the Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be preauthorized in writing by Delta Dental.

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

Treatment In Progress means any single dental 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 procedure whether or not the Enrollee continues to be eligible for Benefits under the DeltaCare USA plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established full or partial dentures for which an impression has been taken and orthodontics when bands have been placed and tooth movement has begun.

We, Us or Our means Delta Dental of California or the Administrator as appropriate.

Eligibility for Benefits

Eligible Employees and Eligible Dependents receive Benefits as soon as they are enrolled in the Program. Subject to cancellation as provided under this Program, enrollment of Eligible Employees and Eligible Dependents is for a minimum period of one year.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include, Primary Enrollee's Spouse (unless legally separated or divorced) and children from birth up to age 26.

Children include natural children, stepchildren, adopted children, and foster children. The dependents of Primary Enrollees are eligible to enroll on the same date that the employee, of whom they are a dependent, becomes a Primary Enrollee. Later-acquired dependents become eligible as soon as they acquire dependent status. However, the Primary Enrollee may delay coverage for young children, under the age of four (4), until the beginning of any Calendar Year immediately following said child's fourth birthday. For coverage to begin on such young children, the eligibility notice and additional Premium payment must be received within 31 days of the beginning of the Calendar Year immediately following said child's fourth birthday.

An overage dependent child may be eligible if:
1) he or she is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 60 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a physically or mentally disabling injury, illness or condition that began before he or she reached the limiting age.

Dependents in active military service are not eligible. No one may be an Eligible Dependent of more than one Eligible Employee. Medicare eligibility shall not affect the eligibility of an Eligible Employee or an Eligible Dependent.

Prepayment Fees/Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

We may cancel the Contract 30 days after written notice to the Client if monthly premiums are not paid when due. The Client will be given a 30 day grace period, which begins immediately following the last day of paid coverage, to pay the monthly premium. During that time, Delta Dental will continue to provide coverage to Enrollees. If the premium remains unpaid at the end of the 30 day grace period,

the Contractholder will notify you that coverage has terminated along with the date of termination.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED IN WRITING BY DELTA DENTAL, OR FOR EMERGENCY SERVICES AS PROVIDED IN *EMERGENCY SERVICES*. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Delta Dental terminates, that Contract Dentist will complete (1) a partial or full denture for which final impressions have been taken, and (2) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Continuity of Care

Current Members:

You may have the right to the benefit of completion of care with your terminated Dentist for certain specified dental conditions. Please call Customer Service at 800-422-4234 to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your terminated Dentist. We are not required to continue your care with that Dentist if you are not eligible under our policy or if we cannot reach agreement with your terminated Dentist on the terms regarding your care in accordance with California law.

New Members:

You may have the right to the qualified benefit of completion of care with an Out-of-Network Dentist for certain specified dental conditions. Please call the Customer Service department at 800-422-4234 to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your current Dentist. We are not required to continue your care with that Dentist if you are not eligible under our policy or if we cannot reach agreement with your Dentist on the terms regarding your care in accordance with California law. This policy does not apply to new Members of an individual subscriber contract.

Special Needs

If an Enrollee believes he or she has a Special Health Care Need, the Enrollee should contact Delta Dental's Customer Service department at 800-422-4234. Delta Dental will confirm that a Special Health Care Need exists, and what arrangements can be made to assist the Enrollee in obtaining such Benefits. Delta Dental shall 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 Dentist treating persons with Special Health Care Needs.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service department at 800-422-4234.

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

If Emergency Services are needed, you should contact your Contract Dentist whenever possible. If you are a new Enrollee needing Emergency Services, but do not have an assigned Contract Dentist yet, contact Delta Dental's Customer Service department at 800-422-4234 for help in locating a Contract Dentist. Benefits for Emergency Services by an Out-of-Network Dentist are limited to necessary care to stabilize your condition and/or provide palliative relief when you:

1) have made a Reasonable attempt to contact the Contract Dentist and the Contract Dentist is unavailable or you cannot be seen within 24 hours of making contact; or
2) have made a Reasonable attempt to contact Delta Dental prior to receiving Emergency Services, or it is Reasonable for you to access Emergency Services without prior contact with Delta Dental; or
3) reasonably believe that your condition makes it dentally/medically inappropriate to travel to the Contract Dentist to receive Emergency Services.

Benefits for Emergency Services not provided by the Contract Dentist are limited to a maximum of $100.00 per emergency, per Enrollee, less the applicable Copayment. If the maximum is exceeded, or the above conditions are not met, you are responsible for any charges for services by a provider other than your Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and preauthorized in writing by Delta Dental. All preauthorized Specialist Services will be paid by us less any applicable Copayments. If an Enrollee is assigned 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.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments*, and the limitations and exclusions to determine which procedures are covered under this Program.

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. Delta Dental 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 rendered by a licensed Dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of imminent and serious health threat 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, contact Delta Dental's Customer Service department at 800-422-4234 or write to Delta Dental.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Delta Dental. Delta Dental will authorize a second opinion by an Out-of-Network provider if an appropriately qualified Contract Dentist is not available. Delta Dental will only pay for a second opinion which Delta Dental has approved or authorized. You will be sent a written notification should Delta Dental decide not to authorize a second opinion. If you disagree with this determination, you may file a grievance with the plan or with the Department of Managed Health Care. Refer to the *Enrollee Complaint Procedure* section for more information.

Claims for Reimbursement

Claims for covered Emergency Services or preauthorized Specialist Services should be submitted to Delta Dental 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. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Provider Compensation

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

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. By statute, the DeltaCare USA provider contract contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental. Except for the provisions in *Emergency Services*, if you have not received Preauthorization for treatment from an Out-of-Network Dentist, and we fail to pay that Out-of-Network Dentist, you may be liable to that Dentist for the cost of services.

You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number shown on the back cover of this booklet.

Processing Policies

The dental care guidelines for the DeltaCare USA Program explain to Contract Dentists what services are covered under the dental Contract. Contract Dentists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist that fall under the scope of Benefits of the dental Program are provided subject to any Copayments. If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a specialist. An Enrollee may contact Delta Dental's Customer Service department at 800-422-4234 for information regarding the dental care guidelines for DeltaCare USA.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or Out-of-Network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

If this plan is secondary, it will pay the lesser of:

1) the amount that it would have paid in the absence of any other dental benefit coverage, or
2) the enrollee's total out-of-pocket cost payable under the primary dental benefit plan as long as the benefits are covered under this plan.

An Enrollee shall provide to Delta Dental and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Delta Dental will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefit paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Delta Dental shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

Quality Management Department
P.O. Box 6050
Artesia, CA 90702

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you may file a request for review (a complaint) with Delta Dental at least 180 days after receipt of the adverse determination. Delta Dental's review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall 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, Delta Dental will provide you with copies of any pertinent documents that are relevant to the benefit determination, 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, Delta Dental shall consult with 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 5 calendar days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a regional dental consultant for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves severe pain and/or imminent and serious threat to a patient's dental health, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the complaint within three days.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care. You may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to your health.

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 **800-422-4234** 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-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Public Policy Participation by Enrollees

Delta Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment program reports and communication from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to: Customer Service Department, P.O. Box 1803, Alpharetta, GA 30023.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless Delta Dental provides notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to any continued coverage option, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be cancelled, or renewal of enrollment refused, in the following events:

1) immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
2) upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Premium is not paid by or on behalf of the Enrollee on the date due. However, the Enrollee may continue to receive Benefits during the 30-day grace period and may be renewed at the end of the Contract Term upon payment of any unpaid Premium; or
   c) Delta Dental demonstrates that the Enrollee committed fraud or an intentional misrepresentation of material fact in obtaining Benefits under the Program.

Cancellation of a Primary Enrollee's enrollment, as described above, shall automatically cancel the enrollment of any of his or her Dependent Enrollees. Any cancellation is subject to the written notification requirements set forth in the Contract and in California law.

If you believe that enrollment has been improperly cancelled, rescinded or not renewed, you may request a review by the Director of the California Department of Managed Health Care of the State of California. Please refer to the *Enrollee Complaint Procedure* section for more information.

Optional Continuation of Coverage (COBRA)

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) and the California Continuation Benefits Replacement Act (or Cal-COBRA, pertaining to employers with two to 19 employees), both require that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period

of continued coverage depends on the Qualifying Event and whether the Enrollee is covered under federal COBRA or Cal-COBRA.

DEFINITIONS

The meaning of key terms used in this section is shown below and apply to both federal and Cal-COBRA.

Qualified Beneficiary means:
1) Enrollees who are enrolled in the Delta Dental plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE UNDER FEDERAL COBRA

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:
1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or

5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

Under federal COBRA law only, when an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

PERIODS OF CONTINUED COVERAGE UNDER CAL-COBRA
(groups of 2 - 19)

In the case of Cal-COBRA, Delta Dental will act as the administrator. Notification and premium payments should be made directly to Delta Dental. Notifications and payments should be delivered by first-class mail, certified mail, or other reliable means of delivery.

Individuals who are eligible for coverage under the federal COBRA law are not eligible for coverage under Cal-COBRA. The employer must notify Delta Dental in writing within 30 days of the date when the employer becomes subject to COBRA.

Qualified Beneficiaries may continue coverage for 36 months following the month in which Qualifying Events 1, 2, 3, 4, or 5 occur.

If, during the 36-month continuation period resulting from Qualifying Event 1, the Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to be disabled on the date of the Qualifying Event or became disabled at any time during the first 60 days of continuation coverage; and notice of the determination is given to the employer during the initial period of continuation coverage and within 60 days of the date of the social security determination letter, the Qualified Beneficiary may continue coverage for a total of 36 months following the month in which Qualifying Event 1 occurs.

This period of coverage will end on the first of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. The Qualified Beneficiary must notify the employer, or administrator within 30 days of any such determination.

If, during the 36-month continuation period resulting from Qualifying Event 1, the Qualified Beneficiary experiences Qualifying Events 2, 3, 4, or 5, he or she must notify the employer within 60 days of the second qualifying event and has a total

of 36 months continuation coverage after the date of the date of the first Qualifying Event.

Delta Dental shall notify the Primary Enrollee of the date his or her continued coverage will terminate. This termination notification will be sent during the 180-day period prior to the end of coverage.

ELECTION OF CONTINUED COVERAGE

A Qualified Beneficiary will have 60 days from a Qualifying Event to give Delta Dental written notice of the election to continue coverage.

Upon written notice, Delta Dental will provide a Qualified Beneficiary with the necessary Benefits information, monthly premium charge, enrollment forms and instructions to allow election of continued coverage.

Failure to provide this written notice of election to Delta Dental within 60 days will result in the loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to Delta Dental, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in the loss of the right to continue coverage and any premiums received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Delta Dental plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Delta Dental plan.

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.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as CDT-2017 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association 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.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost

D0330	Panoramic radiographic image	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15* .	$5.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$5.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$5.00
D1354	Interim caries arresting medicament application - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral	$15.00
D1515	Space maintainer - fixed - bilateral	$15.00
D1520	Space maintainer - removable - unilateral	$15.00
D1525	Space maintainer - removable - bilateral	$15.00
D1550	Re-cement or re-bond space maintainer	No Cost
D1555	Removal of fixed space maintainer	No Cost
D1575	Distal shoe space maintainer - fixed - unilateral - *child to age 9* …	$15.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior [2, 8]	Optional
D2392	Resin-based composite - two surfaces, posterior [2, 8]	Optional
D2393	Resin-based composite - three surfaces, posterior [2, 8]	Optional
D2394	Resin-based composite - four or more surfaces, posterior [2, 8]	Optional
D2510	Inlay - metallic - one surface [4, 9]	No Cost
D2520	Inlay - metallic - two surfaces [4, 9]	No Cost
D2530	Inlay - metallic - three or more surfaces [4, 9]	No Cost
D2542	Onlay - metallic - two surfaces [4, 9]	No Cost
D2543	Onlay - metallic - three surfaces [4, 9]	No Cost
D2544	Onlay - metallic - four or more surfaces [4, 9]	No Cost
D2610	Inlay - porcelain/ceramic - one surface [2, 9]	Optional
D2620	Inlay - porcelain/ceramic - two surfaces [2, 9]	Optional
D2630	Inlay - porcelain/ceramic - three or more surfaces [2, 9]	Optional
D2642	Onlay - porcelain/ceramic - two surfaces [2, 9]	Optional
D2643	Onlay - porcelain/ceramic - three surfaces [2, 9]	Optional
D2644	Onlay - porcelain/ceramic - four or more surfaces [2, 9]	Optional
D2650	Inlay - resin-based composite - one surface [2, 9]	Optional
D2651	Inlay - resin-based composite - two surfaces [2, 9]	Optional
D2652	Inlay - resin-based composite - three or more surfaces [2, 9]	Optional
D2662	Onlay - resin-based composite - two surfaces [2, 9]	Optional
D2663	Onlay - resin-based composite - three surfaces [2, 9]	Optional
D2664	Onlay - resin-based composite - four or more surfaces [2, 9]	Optional
D2710	Crown - resin-based composite (indirect) [1, 9]	$40.00
D2712	Crown - ¾ resin-based composite (indirect) [1, 9]	$40.00
D2720	Crown - resin with high noble metal [1, 4, 9]	$60.00
D2721	Crown - resin with predominantly base metal [1, 9]	$60.00
D2722	Crown - resin with noble metal [1, 9]	$60.00
D2740	Crown - porcelain/ceramic substrate [1, 9]	$60.00
D2750	Crown - porcelain fused to high noble metal [1, 4, 9]	$60.00

D2751	Crown - porcelain fused to predominantly base metal [1, 9]	$60.00
D2752	Crown - porcelain fused to noble metal [1, 9]	$60.00
D2780	Crown - ¾ cast high noble metal [4, 9]	$60.00
D2781	Crown - ¾ cast predominantly base metal [9]	$60.00
D2782	Crown - ¾ cast noble metal [9]	$60.00
D2790	Crown - full cast high noble metal [4, 9]	$60.00
D2791	Crown - full cast predominantly base metal [9]	$60.00
D2792	Crown - full cast noble metal [9]	$60.00
D2794	Crown - titanium [4, 9]	$60.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$10.00
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - *anterior primary tooth*	$10.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$10.00
D2940	Protective restoration	$10.00
D2941	Interim therapeutic restoration - primary dentition	$10.00
D2949	Restorative foundation for an indirect restoration	$10.00
D2950	Core buildup, including any pins when required	$10.00
D2951	Pin retention - per tooth, in addition to restoration	$10.00
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation* [4]	$10.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation* [4]	$10.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$10.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$10.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$12.00
D2980	Crown repair necessitated by restorative material failure	$10.00
D2981	Inlay repair necessitated by restorative material failure	$10.00
D2982	Onlay repair necessitated by restorative material failure	$10.00
D2983	Veneer repair necessitated by restorative material failure	$10.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$5.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	$6.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$6.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$6.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration) [10]	$30.00
D3320	*Root canal* - endodontic therapy, bicuspid tooth (excluding final restoration) [10]	$60.00
D3330	*Root canal* - endodontic therapy, molar (excluding final restoration) [10]	$90.00
D3331	Treatment of root canal obstruction; non-surgical access [10]	$30.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth [10]	$30.00
D3346	Retreatment of previous root canal therapy - anterior [10]	$45.00
D3347	Retreatment of previous root canal therapy - bicuspid [10]	$75.00
D3348	Retreatment of previous root canal therapy - molar [10]	$105.00
D3410	Apicoectomy - anterior [10]	$50.00
D3421	Apicoectomy - bicuspid (first root) [10]	$50.00
D3425	Apicoectomy - molar (first root) [10]	$50.00
D3426	Apicoectomy (each additional root) [10]	No Cost
D3427	Periradicular surgery without apicoectomy	$50.00
D3430	Retrograde filling - per root [10]	$50.00
D3450	Root amputation, per root - *not covered in conjunction with a hemisection* [10]	No Cost

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$75.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$15.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$15.00

D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$75.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$75.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$150.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$150.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - *limited to 1 treatment in any 12 consecutive months*	No Cost
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	No Cost
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110	Complete denture - maxillary [5, 6]	$75.00
D5120	Complete denture - mandibular [5, 6]	$75.00
D5130	Immediate denture - maxillary [5, 6]	$90.00
D5140	Immediate denture - mandibular [5, 6]	$90.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) [5, 6]	$85.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) [5, 6]	$85.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [5, 6]	$85.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [5, 6]	$85.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$85.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$85.00

D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$85.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$85.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth) [5, 6]	$135.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth) [5, 6]	$135.00
D5410	Adjust complete denture - maxillary [5]	No Cost
D5411	Adjust complete denture - mandibular [5]	No Cost
D5421	Adjust partial denture - maxillary [5]	No Cost
D5422	Adjust partial denture - mandibular [5]	No Cost
D5510	Repair broken complete denture base	$15.00
D5520	Replace missing or broken teeth - complete denture (each tooth) .	$5.00
D5610	Repair resin denture base	$15.00
D5620	Repair cast framework	$15.00
D5630	Repair or replace broken clasp - per tooth	$15.00
D5640	Replace broken teeth - per tooth	$5.00
D5650	Add tooth to existing partial denture	$5.00
D5660	Add clasp to existing partial denture - per tooth	$5.00
D5710	Rebase complete maxillary denture [12]	$30.00
D5711	Rebase complete mandibular denture [12]	$30.00
D5720	Rebase maxillary partial denture [12]	$30.00
D5721	Rebase mandibular partial denture [12]	$30.00
D5730	Reline complete maxillary denture (chairside) [12]	$15.00
D5731	Reline complete mandibular denture (chairside) [12]	$15.00
D5740	Reline maxillary partial denture (chairside) [12]	$15.00
D5741	Reline mandibular partial denture (chairside) [12]	$15.00
D5750	Reline complete maxillary denture (laboratory) [12]	$30.00
D5751	Reline complete mandibular denture (laboratory) [12]	$30.00
D5760	Reline maxillary partial denture (laboratory) [12]	$30.00
D5761	Reline mandibular partial denture (laboratory) [12]	$30.00
D5820	Interim partial denture (maxillary) - *limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing* [5]	No Cost
D5821	Interim partial denture (mandibular) - *limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing* [5]	No Cost
D5850	Tissue conditioning, maxillary [5, 12]	No Cost
D5851	Tissue conditioning, mandibular [5, 12]	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

D6210	Pontic - cast high noble metal [4, 7]	$60.00
D6211	Pontic - cast predominantly base metal [7]	$60.00
D6212	Pontic - cast noble metal [7]	$60.00
D6240	Pontic - porcelain fused to high noble metal [1, 4, 7]	$60.00
D6241	Pontic - porcelain fused to predominantly base metal [1, 7]	$60.00
D6242	Pontic - porcelain fused to noble metal [1, 7]	$60.00
D6245	Pontic - porcelain/ceramic [2, 7]	Optional
D6250	Pontic - resin with high noble metal [1, 4, 7]	$60.00
D6251	Pontic - resin with predominantly base metal [1, 7]	$60.00
D6252	Pontic - resin with noble metal [1, 7]	$60.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces [2, 7]	Optional
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces [2, 7]	Optional
D6602	Retainer inlay - cast high noble metal, two surfaces [4, 7]	No Cost
D6603	Retainer inlay - cast high noble metal, three or more surfaces [4, 7]	No Cost
D6604	Retainer inlay - cast predominantly base metal, two surfaces [7]	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces [7]	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces [7]	No Cost
D6607	Retainer inlay - cast noble metal, three or more surfaces [7]	No Cost
D6608	Retainer onlay - porcelain/ceramic, two surfaces [2, 7]	Optional
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces [2, 7]	Optional
D6610	Retainer onlay - cast high noble metal, two surfaces [4, 7]	No Cost
D6611	Retainer onlay - cast high noble metal, three or more surfaces [4, 7]	No Cost
D6612	Retainer onlay - cast predominantly base metal, two surfaces [7]	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces [7]	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces [7]	No Cost
D6615	Retainer onlay - cast noble metal, three or more surfaces [7]	No Cost
D6720	Retainer crown - resin with high noble metal [1, 4, 7]	$60.00
D6721	Retainer crown - resin with predominantly base metal [1, 7]	$60.00
D6722	Retainer crown - resin with noble metal [1, 7]	$60.00
D6740	Retainer crown - porcelain/ceramic [2, 7]	Optional
D6750	Retainer crown - porcelain fused to high noble metal [1, 4, 7]	$60.00
D6751	Retainer crown - porcelain fused to predominantly base metal [1, 7]	$60.00
D6752	Retainer crown - porcelain fused to noble metal [1, 7]	$60.00
D6780	Retainer crown - ¾ cast high noble metal [4, 7]	$60.00
D6781	Retainer crown - ¾ cast predominantly base metal [7]	$60.00

D6782	Retainer crown - ¾ cast noble metal [7]	$60.00
D6790	Retainer crown - full cast high noble metal [4, 7]	$60.00
D6791	Retainer crown - full cast predominantly base metal [7]	$60.00
D6792	Retainer crown - full cast noble metal [7]	$60.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker [7]	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	$15.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - deciduous tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No Cost
D7220	Removal of impacted tooth - soft tissue	No Cost
D7230	Removal of impacted tooth - partially bony	$30.00
D7240	Removal of impacted tooth - completely bony	$40.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$40.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	$40.00
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$30.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$30.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$40.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$40.00
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost

D8000-D8999 XI. ORTHODONTICS

D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* [11]	$1,600.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* [11]	$1,600.00

D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children* [11]	$1,800.00
D8660	Pre-orthodontic treatment examination to monitor growth and development - *not to be charged with any other consultation procedure(s)* [3]	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) [13]	No Cost
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes START-UP FEES, (including initial examination, diagnosis, consultation and initial banding)*	$350.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$5.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for deep sedation or general anesthesia	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost

FOOTNOTES

1 *Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of $150.00.*

2 *Optional is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the program. The applicable charge to the Enrollee is the difference between the Contract Dentist's "filed fee" for the Optional procedure and the "filed fee" for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are benefits. "Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding the DeltaCare USA program should be directed to Delta Dental's Customer Service department at 800-422-4234.*

3 *In the event comprehensive orthodontic treatment is not required or is declined by the Enrollee, a fee of $25.00 will apply. The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.*

4 *Base or noble metal is the benefit. If a crown, pontic, inlay, onlay or indirectly fabricated post and core is made of high noble metal, an additional fee up to $100.00 per tooth will be charged for the upgrade. This charge also applies to a titanium crown.*

5 *Includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement, if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.*

6 *Replacement is subject to a limitation requiring the existing denture to be 5+ years old.*

7 *Replacement is subject to a limitation requiring the existing bridge to be 5+ years old.*

8 *An amalgam is the Benefit.*

9 *Replacement is subject to a limitation requiring the existing restoration to be 5+ years old.*

10 *A Benefit for permanent teeth only.*

11 *Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 (Start-up fee). Beyond 24 months of active treatment, an additional monthly fee of $75.00 applies.*

12 *Limited to 1 per denture during any 12 consecutive months.*

13 *Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee of $75.00 applies.*

SCHEDULE B

Limitations of Benefits

1. Full mouth x-rays are limited to one set every 24 consecutive months and include any combination of periapicals, bitewings and/or panoramic film.
2. Bitewing x-rays are limited to not more than one series of four films in any six month period.
3. Diagnostic casts are limited to aid in diagnosis by the Contract Dentist for covered benefits.
4. If a biopsy is preauthorized by Delta Dental for an oral surgeon, then examination of the resulting biopsy specimen is covered under codes D0472, D0473 or D0474 and available at no additional cost.
5. Prophylaxis or periodontal maintenance is limited to one procedure each six month period.
6. Benefits for sealants include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars through age nine and second molars through age 15. Benefits for sealants do not include the repair or replacement of a sealant on any tooth within three years of its application.
7. A filling is a benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
8. A crown 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 limitation (Limitation #12).
9. A covered metallic inlay, onlay, crown or fixed partial denture (bridge) using base or noble metal is available for listed Copayment(s). If the Enrollee elects to have high noble metal used instead, the maximum additional cost of this material upgrade is $100.00 per tooth or pontic. For an indirectly fabricated post and core, the benefit is for base or noble metal. If the Enrollee elects to have a high noble metal indirectly fabricated post and core instead, the maximum additional cost of this material upgrade is $100.00 per tooth.
10. For molars, a covered inlay, onlay, crown, or unit of a fixed partial denture (bridge) is metallic without porcelain or other tooth-colored material. If the Enrollee elects to have porcelain, porcelain-fused-to-metal, resin or resin-with-metal used instead, the maximum additional cost for this tooth-colored material upgrade is $150.00 per molar.

11. If a porcelain margin is also chosen by the Enrollee for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is $75.00.
12. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture 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 prior to its replacement, **or**
        - If an existing partial denture is less than five years old, 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.
13. A direct or indirect pulp cap is a benefit only on a vital permanent tooth with an open apex or a vital primary tooth.
14. With the exception of pulp caps and pulpotomies, endodontic procedures (e.g. root canal therapy, apicoectomy, retrofill, etc.) are only a benefit on a permanent tooth.
15. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.
16. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
17. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.
18. Coverage for the placement of a fixed partial denture (bridge) or removable partial denture:
    a. Fixed partial denture (bridge):
        - 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 (see Limitation #12) **or**
        - Each abutment tooth to be crowned meets Limitation #8.
    b. Removable partial denture:
        - Cast metal (D5213, D5214), one or more teeth are missing in an arch.
        - Resin based (D5211, D5212), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease (see Limitation #12).

19. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.
20. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to:
    - The replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture **or**
    - The replacement of permanent tooth/teeth for children under 16 years of age.
21. Retained primary teeth shall be covered as primary teeth.
22. Excision of the frenum is a benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.
23. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
24. In cases of accidental injury, benefits available are described in *Schedule B, Accident Injury Benefit*. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function, exclusive attrition and normal wear, will be covered as described in *Schedules A, Description of Benefits and Copayments; and B, Limitations and Exclusions of Benefits.*
25. 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.
26. A new removable partial, complete or immediate denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.
27. An Optional procedure is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Program. The applicable charge to the Enrollee is the difference between the Contract Dentist's "filed fee" for the Optional procedure and the "filed fee" for the covered procedure, plus any applicable Copayment for the covered procedure.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Dental conditions arising out of and due to Enrollee's employment for which Workers' Compensation is paid. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision, except as provided in Section 1373(a) of the California Health and Safety Code.
3. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
6. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress, orthodontics, unless qualified for the orthodontic treatment in progress provision.
7. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.), except for the treatment of newborn children with congenital defects or birth abnormalities.
8. Dispensing of drugs not normally supplied in a dental facility.
9. Any procedure that in the professional opinion of the Contract Dentist:
   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.
10. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized in writing by Delta Dental or as cited under *Emergency Services.* To obtain written authorization, the Enrollee should call Delta Dental's Customer Service department at 800-422-4234.
11. Consultations for non-covered benefits.
12. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
13. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.

14. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

15. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ).

16. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth reconstruction under the DeltaCare USA program. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusion does not eliminate the benefit for other covered services.

17. 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.

18. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions.

19. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.

Orthodontic Limitations

The DeltaCare USA program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The start-up fees and the cost to the Enrollee for the treatment plan are listed in *Schedule A, Description of Benefits and Copayments* and subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist.
2. Benefits cover 24 months of active comprehensive orthodontic treatment. Included is the initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustment to retainers and office visits for a maximum of two years.
3. Treatment plans extending beyond 24 months of active treatment, or 24 months of the retention phase of treatment will be subject to a monthly office visit fee to the Enrollee not to exceed $75.00 per month.
4. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not Delta Dental will be responsible for payment of any balance due for treatment provided after cancellation or termination. In such a case the Enrollee's payment shall be based on a maximum of $2,800.00 for covered dependent children to age 19 and $3,000.00 for covered adults and dependent children to age 23. The amount will be prorated over the number of months to completion of the treatment and, will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the Contract Orthodontist.
5. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation have been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of $25.00 in addition to diagnostic record fees.
6. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are benefits. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the Contract Orthodontist's "filed fees."
7. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the Enrollee's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the Contract Orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same Copayment amounts as for fixed appliances.

8. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Orthodontic Exclusions

1. Pre-, mid- and post-treatment records which include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances.
3. Retreatment of orthodontic cases.
4. Changes in treatment necessitated by accident of any kind.
5. Initial or continuing orthodontic treatment when such treatment would be inconsistent with generally accepted professional standards.
6. Surgical procedures incidental to orthodontic treatment.
7. Myofunctional therapy.
8. Surgical procedures related to cleft palate, micrognathia or macrognathia.
9. Treatment related to temporomandibular joint disturbances.
10. Supplemental appliances not routinely used in typical comprehensive orthodontics.
11. Restorative work caused by orthodontic treatment.
12. Phase I orthodontics, as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.
13. Extractions solely for the purpose of orthodontics.
14. Treatment in progress at inception of eligibility, unless qualified for the orthodontic treatment in progress provision.
15. Composite bands, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

Accident Injury Benefit

An accidental injury is damage to the hard and soft tissue of the mouth caused directly and independently of all other causes by external forces. Damage to the hard and soft tissue of the mouth from normal chewing function is covered under *Schedule A, Description of Benefits and Copayments*.

Delta Dental will pay up to 100 percent of the Contract Dentist's "filed fees," for expenses an Enrollee incurs for an accident injury, less any applicable Copayment(s), up to a Maximum of $1,600.00 in any 12 month period.

Accident injury benefits include the following procedure in addition to those listed in *Schedule A, Description of Benefits and Copayments*.

CODE

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus - includes splinting and/or stabilization.

Payment of accident injury benefits is subject to *Schedule B, Limitations and Exclusions of Benefits*, in addition to the following provisions:

MAXIMUM

Accident injury benefits will be provided for each Enrollee up to a maximum of $1,600.00 in any 12 month period.

LIMITATION

Accident injury benefits are limited to services provided as a result of an accident which occurred (a) while the Enrollee was covered under the DeltaCare USA program, or (b) while the Enrollee was covered under another DeltaCare USA program, and if the benefits for the expenses incurred would have been paid if the Enrollee had remained covered under that program.

EXCLUSIONS

In addition to *Schedule B*, limitations #13, #15, #20, #21 and #24 and exclusions #1-9, #11-15 and #18-20, the following exclusions apply:

1. Prophylaxis.
2. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
3. Replacement of existing restorations due to decay.
4. Orthodontic services (treatment of malalignment of teeth and/or jaws).
5. Replacement of existing restorations, crowns, bridges, dentures and other dental or orthodontic appliances damaged by accident injury.

"Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to Delta Dental's Customer Service department at 800-422-4234.

Non-Discrimination Disclosure

Discrimination is Against the Law

Delta Dental complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Delta Dental does 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. Delta Dental 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. Delta Dental 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 Delta Dental has 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
P.O. Box 997330
Sacramento, CA95899-7330
Telephone Number 1-866-530-9675
Website Address: 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, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Delta Dental provides 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)

Delta Dental also provides 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 Delta Dental customer Service 1-866-530-9675.

Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call 1-800-422-4234 (TTY: 711).

¿Puede leer este documento? Si no, podemos hacer que alguien lo lea por usted. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 1-800-422-4234 (TTY: 711). (Spanish)

您能自行閱讀本文件嗎？如果不能，我們可請人幫助您閱讀。您還可以請人以您的語言撰寫本文件。如需免費幫助，請致電 1-800-422-4234 (TTY: 711)。(Chinese)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 1-800-422-4234 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 그렇지 않다면, 다른 사람이 대신 읽어드리도록 도와드릴 수 있습니다. 또한 이 문서를 귀하의 모국어로 번역해드릴 수 있습니다. 무료 지원을 요청하시려면, 1-800-422-4234 (TTY: 711)번으로 연락하십시오. (Korean)

Mababasa mo ba ang dokumentong ito? Kung hindi, mayroong makatutulong sa iyo na basahin ito. Maaaring makuha mo rin ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-800-422-4234 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, то вы можете попросить кого-нибудь в нашей компании помочь вам прочитать этот документ. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-800-422-4234 (TTY: 711). (Russian)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع, يمكننا أن نُوفّر لك من يساعدك في قراءتها. ربما يمكنك أيضًا الحصول على هذا المستند مكتوبًا بلغتك. للمساعدة المجانية اتصل بـ 1-800-422-4234 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-800-422-4234 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n’est pas le cas, nous pouvons faire en sorte que quelqu’un vous aide à le lire. Vous pouvez également obtenir ce

document écrit dans votre langue. Pour obtenir de l'assistance gratuitement, veuillez appeler le 1-800-422-4234 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-800-422-4234 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-800-422-4234 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche essere in grado di ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-800-422-4234 (TTY: 711). (Italian)

この文書をお読みになれますか？お読みになれない場合には、読むためのお手伝いをさせていただけます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、1-800-422-4234（TTY: 711）までご連絡ください。(Japanese)

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 1-800-422-4234 (TTY: 711). (German)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخواهیا تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 1-800-422-4234 (TTY: 711). (Persian Farsi)

קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט, עמעצער דו קען אייך העלפן לייענען. איר קענט מעגליך אויך באקומען דעם דאָזיקן דאָקומענט אין אייער שפּראַך. פּאר אומזיסטע הילף, ביטע קלינגט: 1-800-422-4234 (TTY: 711). (Yiddish)

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'į' yídóołtahígíí nihee hóló. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaago ałdó' nich'į' ádoolníłgo bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojį' béésh holdíílnih 1-800-422-4234 (TTY: 711). (Navajo)

LAP_DCU

If you have any questions or need additional information, call or write:

Toll Free
800-422-4234

Delta Dental of California
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703