This Package Contains the Following Documents

- 2023 Group Agreement Summary of Changes and Clarifications
- California Health Benefit Exchange SHOP Program Model Supplement Rider to Group Subscriber Agreement
- Group Agreement for Covered California for Small Business
- DeltaCare® USA Group Dental Service Contract

2023 *Group Agreement* Summary of Changes and Clarifications Notice For Effective Dates from January 1, 2023 through December 1, 2023

This *Group Agreement Summary of Changes and Clarifications Notice ("Notice")* includes a summary of the changes and clarifications that will be effective when your *Group Agreement* ("*Agreement*") is renewed in 2023, unless a different effective date is stated. Unless otherwise indicated, the changes and clarifications described here apply to each type of coverage that will be effective upon renewal of your *Agreement*.

In certain circumstances, this *Notice* may also include changes that we made to your *Agreement* during the 2022 plan year through an amendment. This *Notice* does not include minor changes and clarifications that Health Plan is making to improve the readability of the *Agreement* or any changes Covered California for Small Business is making. In addition to the changes and clarifications listed below, we will also make any changes required by law or by any state or federal agency.

Note: Some capitalized terms in this *Notice* have special meaning. Please see the "Definitions" section of the applicable *Evidence of Coverage* ("*EOC*") document in your *Agreement* for terms you should know.

Global Changes to the *Agreement*, including *EOC* documents

Accrual Toward Deductibles and Out-of-Pocket Maximums (SB 368)

For consistency with state law, *we moved information about keeping track of deductibles and out-of-pocket maximums to a new section called "Accrual toward deductibles and out-of-pocket maximums" under "Your Cost Share" in the "Benefits" section of EOCs. This section describes how members can find out how close they are to reaching these limits and how they can change their delivery preference for required notices about accruals toward these limits.*

Drug Manufacturer Coupons

Due to a change in policy, *in HSA-Qualified High Deductible Health Plans we accept certain manufacturer coupons for prescription drugs, effective January 1, 2022. A description of the Kaiser Permanente coupon program is under "Manufacturer coupon program" in the "Outpatient Prescription Drugs, Supplies, and Supplements" section of EOCs:*

> ***Manufacturer coupon program***
>
> For outpatient prescription drugs or items that are covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section and obtained at a Plan Pharmacy, you may be able to use approved manufacturer coupons as payment for the Cost Share that you owe, after reaching your applicable deductible amount and as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of your Cost Share for your prescription. When you use an approved coupon for payment of your Cost Share, the coupon amount and any additional payment that you make will accumulate to your out-of-pocket maximum. Refer to the "Cost Share Summary" section of this EOC to find your applicable out-of-pocket maximum amount and to learn which drugs and items apply to the maximum. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at **kp.org/rxcoupons**.

Fertility Services

Due to a change in policy*, beginning January 1, 2023, diagnostic Services (sleep apnea studies and electrocardiograms) related to fertility treatment will be covered under "Outpatient imaging, laboratory, and other diagnostic and treatment Services" instead of "Fertility Services" in the EOC. In some plans, this may result in lower Cost Share for these Services. In accord with this change, we have also added a new cross-reference in the "Fertility Services" section, referring members to the "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services" section of the EOC for information on diagnostic Services.*

HRSA-related EOC Changes

We have made the following changes to EOCs, ***to align with guidance released by the United States Health Resources and Services Administration ("HRSA")****:*

- *Under "Breastfeeding Supplies" in the "Durable Medical Equipment "DME" for Home Use" section, we have clarified that we cover supplies associated with breastfeeding, as described on our website at* ***kp.org/prevention***
- *In the "Contraceptive drugs and devices" table under "Outpatient prescription drugs, supplies, and supplements" in the "Cost Share Summary," we have deleted the reference to "female condoms" and added "condoms" instead. Female and male condoms are both covered when prescribed for women, up to a 30-day supply. This change does not apply to EOCs for religious purchasers that do not cover contraception*
- *Under "Preventive Services" in the "Cost Share Summary," we have clarified that postpartum follow-up visits are covered when Medically Necessary. Additionally, postpartum follow-up visits will no longer be subject to the Plan Deductible in HSA-Qualified High Deductible Health Plans*

Renewal

For consistency with state law*, under "Renewal" in the "Term of Agreement and Renewal" section of Agreements, we have removed the specific timeframe for providing prior written notice of any offer to renew the Agreement. Notice will be provided in a timely manner, consistent with applicable state and federal requirements.*

Timely Access to Care (SB 221)

In accordance with state law*, under "Timely Access to Care" in the "How to Obtain Services" section of EOCs, we have added a new access standard for follow-up (non-urgent) mental health care or substance use disorder treatment appointments with a practitioner other than a physician, for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition. We have also reorganized this section for readability and to better align with the terminology in state law.*

Global Clarifications to the *Agreement,* including *EOC* documents

Claims

Under "Initial Claims" in the "Post-Service Claims and Appeals" section of *EOCs*, we have clarified the process by which a member may submit a claim for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services.

Confidential Information (AB 1184)

Under "Privacy Practices" in the "Miscellaneous Provisions" section of *EOCs*, we have clarified that a member may request a confidential communication by completing a confidential communication request form available on **kp.org**.

Deductibles and Out of Pocket Maximums

Under "Deductibles and Out-of-Pocket Maximums" in the "Cost Share Summary" section of *EOCs*, we have clarified that if a Member experiences a plan change in the middle of their current Accumulation Period, their deductible and out-of-pocket maximum amounts may increase or decrease, therefore changing the amount that must accumulate during their current Accumulation Period.

Dependent Foster Children

Under "Eligibility as a Dependent" in the "Who is Eligible" section of *EOCs*, we have replaced the bullet point describing foster child eligibility with a new bullet point stating that foster children are eligible to enroll as Dependents under the plan, if the Subscriber or Spouse has the legal authority to direct their care. Groups continue to be required to allow enrollment of eligible foster children during a special enrollment period triggered by the placement of the child in foster care, and may also allow enrollment of foster children at other times in accord with Group's eligibility requirements.

Grievances

Under "How to file" in the "Grievances" section of *EOCs*, we have clarified the process by which a member may submit a claim or grievance electronically, orally, or in writing.

Mail Order Service

Under “Mail-order service” in the “Outpatient Prescription Drugs, Supplies, and Supplements” section of *EOCs*, we have updated the mailing timeframe for prescription refills from “7 to 10 days” to “3 to 5 days” to align with other Plan materials. Additionally, we have revised the “note” in this section for clarity and to explain that prescription drugs cannot be mailed to all states.

Notices

Under “Notices Regarding Your Coverage” in the “Miscellaneous Provisions” section of *EOCs*, we have clarified that a Subscriber is responsible for notifying their Group of any change in contact information.

Receiving Care Outside of Your Home Region Service Area

Under “Receiving Care Outside of Your Home Region Service Area” in the “How to Obtain Services” section of *EOCs*, we have simplified the description of how to receive care when you are away from your Home Region.

Surrogacy

We have moved the definition of Surrogacy Arrangements to the “Definitions” section of the *EOC*. Previously this definition appeared in two places in the *EOC*: under “Surrogacy” in the “Exclusions” section and under “Surrogacy Arrangements” in the “Reductions” section.

Termination for Nonpayment of Cal-COBRA Premiums

We have simplified language describing the termination process under "Termination for nonpayment of Cal-COBRA Premiums" in the "Continuation of Membership" section of *EOCs*. The details removed from this section can be found in the notices sent to Members regarding nonreceipt of payment and termination for nonpayment of Cal-COBRA Premiums.

CALIFORNIA HEALTH BENEFIT EXCHANGE SHOP PROGRAM
MODEL SUPPLEMENT RIDER
TO
GROUP SUBSCRIBER AGREEMENT

This California Health Benefit Exchange Small Business Health Options (SHOP) Program Supplement Rider (the "Supplement") supplements that certain Group Subscriber Agreement (the "Agreement") between Health Plan or Insurance Issuer (HEALTH PLAN) and GROUP. This Supplement is an integral part of the Agreement and is intended by the Parties hereto to be interpreted to be consistent therewith; any inconsistencies or conflicts in terms with the Agreement are to be resolved in favor of the terms in this Supplement.

WHEREAS, GROUP is eligible to participate in the Small Business Health Options Program Exchange and desires to offer its Employees a range of choice of health care plans from which to receive their health care; and

WHEREAS, HEALTH PLAN is a participant in the SHOP Program, as defined below; and

WHEREAS, at least one Employee of GROUP has selected HEALTH PLAN, through HEALTH PLAN's participation in the SHOP Program, as the health care service plan or insurance issuer from which to receive his or her health care.

THEREFORE, HEALTH PLAN and GROUP have entered into the Agreement, as supplemented by this Supplement.

I. DEFINITIONS

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) is that program operated by the California Health Benefit Exchange, also known as Covered California through which a small employer can provide its employees and their dependents with access to one or more products offered by HEALTH PLAN.

ELIGIBLE EMPLOYEE is an employee as defined in Section 1357.500(c) of California Health and Safety Code and in Section 10753(f) of California Insurance Code

ENROLLEE shall mean an individual and his or her eligible dependents, as defined by HEALTH PLAN, who lives or works in an approved Service Area, who meets the eligibility requirements of GROUP and HEALTH PLAN, who has made application to HEALTH PLAN through the SHOP Program, and for whom premiums have been paid by GROUP or individually as a COBRA or Cal-COBRA participant.

MEMBER shall mean an individual who is covered for health care services by HEALTH PLAN, but who may or may not have obtained coverage through the SHOP.

NET PREMIUM shall mean the monthly amount paid to HEALTH PLAN by GROUP through SHOP for health care coverage of GROUP's Enrollees, which shall consist of the Premium minus authorized expenses of SHOP deducted pursuant to this Supplement.

PARTICIPATING PLAN shall mean a HEALTH PLAN, offering health maintenance organization (HMO) or preferred provider (PPO) products and participating in the SHOP. HEALTH PLAN is a Participating Plan.

PARTICIPATING PROVIDER shall mean a health care provider, individual or institution, who or which is employed by or under contract with HEALTH PLAN to provide designated health care services to HEALTH PLAN's Members.

PREMIUM shall mean the monthly amount charged to and payable by Subscribing Groups or COBRA or Cal-COBRA subscribers for health care coverage from HEALTH PLAN (including commissions, administrative expenses, billing fees, taxes or license fees, if any), and the payment of which entitles Enrollees to the health care coverage offered under the terms of the Agreement.

QUALIFIED HEALTH PLAN (QHP) has the same meaning as that term is defined in Patient Protection and Affordable Care Act Section 1301 (42 USC § 18021).

SERVICE AREA shall mean that geographic area in which HEALTH PLAN is licensed to offer and provide QHPs to Small Group Employers.

SMALL GROUP EMPLOYER shall mean a "small employer" as defined in Section 1357.500(k) of California Health and Safety Code and Section 10753(q) of California Insurance Code.

SMALL GROUP MARKET shall mean the aggregation of Small Group Employers in the state of California.

SUBSCRIBING GROUP or SUBSCRIBING EMPLOYER shall mean an organization or firm, which applied for health care coverage by a PARTICIPATING PLAN through the SHOP, was screened for compliance with SHOP's eligibility criteria, and was accepted by SHOP for participation. The Subscribing Group contracts directly with HEALTH PLAN to arrange for the provision of health care services for its Employees or Members and/or their spouses or domestic partners and/or their dependents. GROUP upon execution of the Agreement, as modified by this Supplement, is a Subscribing Group.

II. THE SHOP

The SHOP is a mechanism in which HEALTH PLAN and other health care service plans and insurance issuers simultaneously offer Qualified Health Plans (QHP) to Small Group Employers.

A. Contribution and Participation Requirements

HEALTH PLAN and GROUP understand and agree to the following contribution and participation requirements for the provision of services pursuant to the Agreement.

1. For medical coverage, GROUP must contribute a minimum of the equivalent of fifty percent (50%) of the Premium cost of the Employee-only rate in the reference plan selected by the Employer.

2. For medical coverage, GROUP must have a minimum of seventy percent (70%) of Eligible Employees enroll in a QHP through the SHOP. If the Group pays 100 percent of its Qualified Employees' QHP premiums, then all Eligible Employees must enroll in health coverage through the SHOP. For purposes of participation, eligible employees are not included in the calculation for minimum participation requirements if they are enrolled in coverage through another employer, an employee's union, Medicaid, Medicare, any other federal or state health coverage programs, or any health coverage meeting the definition of minimum essential coverage pursuant to Health and Safety Code Section 1345.5

3. If GROUP does not meet such minimum contribution and minimum participation requirements, GROUP may only enroll with HEALTH PLAN

through SHOP from November 15th through December 15th of each year.

III. ELIGIBILITY AND ENROLLMENT

A. Eligibility and Enrollment for Open Enrollment

SHOP is responsible for determining eligibility for all GROUPs and applicant Employees of GROUP and their dependents. Except for special enrollments addressed below, coverage effective dates will be determined pursuant to 10 CCR Section 6536.

Employee Eligibility

A Qualified Employee is an employee who has been offered coverage by his or her employer and who is an Eligible Employee.

Dependent Eligibility

1. A dependent claiming eligibility hereunder as a spouse must be legally married to a Qualified Employee.

2. A dependent claiming eligibility hereunder as a domestic partner must be a registered domestic partner, as defined in section 297 and 299.2 of the California Family Code. For an Employee's unregistered domestic partner to be eligible for coverage, the Employer must make an offer of coverage to the Employee's unregistered domestic partner and the eligibility of unregistered domestic partners must be documented in Employer's Employee Benefit Plan documents. It is the Employer's responsibility to ensure that unregistered domestic partnerships are eligible under the terms and conditions of the Employer's plan.

3. A dependent child claiming eligibility hereunder must be born to, a step-child or legal ward of, adopted by or placed in the foster care of the Eligible Employee or the Eligible Employee's spouse or domestic partner, a minor child ordered by a court to be covered by an employee's Plan, or a child for whom the employee has assumed a parent-child relationship and under the age of 26 unless disabled.

4. A dependent child who exceeds the age limit for dependent children and is disabled, who is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to attainment of age, until termination of such incapacity shall be considered eligible. A disabled child who is age 26 or over will be enrolled at the time of initial enrollment of the employee provided that satisfactory evidence of such disability is provided to the PLAN, if requested by the PLAN, within 60 days of the initial enrollment. The PLAN shall provide this information to SHOP within 60 days.

5. For a child that is enrolled, SHOP will provide a 90-day notice that a dependent is about to reach the age limit for dependent children and will lose coverage unless provided with written certification from a competent health care professional, within 60 days of receiving this 90-day notice, that the dependent meets the above conditions of being disabled.

Documentation of eligibility and existence of the relationship of any dependent to the Qualified Employee may be requested at the time of enrollment and before a child attains the limiting age, but not more frequently than annually after the two-year period following a child's attainment of the limiting age.

B. Eligibility and Enrollment for Special Enrollment

1. Newly Eligible Employee

An employee who becomes a qualified employee outside of the initial employee open enrollment period, the annual employee open enrollment period, or a special enrollment period shall have a 30-day period to enroll in a QHP beginning from the first day the employee becomes a qualified employee.

2. New Dependents – Spouse or Registered Domestic Partnership

An eligible spouse or registered domestic partner may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of GROUP or due to one of the following special enrollment qualifying events if the application for coverage, along with any supporting documentation is received by SHOP within 30 calendar days of the event. Coverage will become effective on the first day of the month following the receipt of the application for coverage.

When an employee is newly married or has a newly registered domestic partnership, he or she must submit a stamped copy of the Marriage Certificate or the date the Declaration of Domestic Partnership is filed with the California Secretary of State if requested by SHOP.

When an employee gains a child dependent, the employee may enroll a spouse or registered domestic partner to the Plan during the same special enrollment period as the newly gained child dependent.

3. New Dependents - Birth/Adoption/Legal Guardianship/Assumption of a Parent-Child Relationship

An individual who becomes a new dependent by virtue of birth, placement for adoption or foster care, assumption of a parent-child relationship, or legal guardianship is eligible for coverage under the Agreement, as modified by this Supplement, at other than the Employer's initial or annual open enrollment, and the appropriate request form should be received by SHOP within 30 days after such birth, placement for adoption, placement in foster care or effective date of a guardianship order, with coverage to be effective upon the date of the birth, placement for adoption, foster care placement, assumption of parent-child relationship, or legal guardianship assignment unless the Employee requests the coverage to be effective on the first day of the month following the date of the birth, placement for adoption, foster care placement, assumption of parent-child relationship, or legal guardianship assignment. The first 31 days of coverage for such new or adopted child is automatic, regardless of whether the child is enrolled or not after this 31-day period.

If application is not received by the 30th day after the birth, adoption, placement, assignment, or assumption of parent-child relationship, the HEALTH PLAN providing coverage for the covered parent will only provide coverage for the first 31 days from the event under that parent's policy. After that time, the dependent child will no longer have coverage.

4. New Dependents – Unregistered Domestic Partnership

If an employer offers coverage to unregistered domestic partners, the SHOP must receive an application for coverage of an unregistered domestic partner by the 30th day after the establishment of the unregistered domestic partnership. Coverage will be effective on the first of the month following the receipt of the application for coverage of the unregistered domestic partner by SHOP.

Employers must agree to notify SHOP immediately upon termination of the unregistered domestic partnership.

5. Loss of Coverage – Qualified Employee and Dependents

A. A Qualified Employee or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they experience a loss of Minimum Essential Coverage due to one of the events listed below. Receipt of the application for coverage and any supporting documents must be within 30 days of the event. Coverage will become effective on the first day of the month following the loss of coverage:

a. loss of eligibility for health insurance coverage due to:
1. legal separation;
2. divorce;
3. cessation of dependent status;
4. termination of employment; or
5. reduction in the number of hours of employment

b. Termination of qualified employer contributions toward the employee's or dependent's health insurance coverage

c. exhaustion of COBRA or Cal-COBRA coverage.

B. A Qualified Employee and/or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they experience a loss of Minimum Essential Coverage due to the loss of coverage through Medicare or Medi-Cal or other government sponsored health care program. Receipt of the application for coverage and any supporting documents must be within **60 days** of the event. Coverage will become effective on the first day of the month following the loss of coverage.

6. Other Special Enrollment Events

A. A Qualified Employee and/or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they experience one of the events listed below. Receipt of the application for coverage and any supporting documents must be within **30 days** of the event. Coverage will become effective on the first day of the month following the loss of coverage.

a. The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.

b. The Qualified Employee, spouse or registered domestic partner or eligible dependent child's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or

inaction of an officer, employee, or agent of the Exchange or HHS or its instrumentalities as evaluated and determined by the Exchange.

c. The Qualified Employee, spouse or registered domestic partner or eligible dependent child adequately demonstrates to the Exchange that the QHP in which he or she is enrolled, substantially violated a material provision of its contract in relation to the qualified employee.

d. A qualified employee or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move and either-
(A) Had MEC as described in 26 CFR Section 1.5000A-1(b) (December 26, 2013), hereby incorporated by reference, for one or more days during the 60 days preceding the permanent move; or
(B) Was living outside of the United States or in a United States territory at the time of the permanent move.

e. Was released from incarceration, or is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active-duty service under Title 32 of the United States Code;

f. An Indian, as defined by Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603(c)), may enroll in a QHP or change from one QHP to another one time per month.

g. A qualified employee or dependent is receiving services from a contracting provider under a health benefit plan, as defined in Section 1399.845(f) of the Health and Safety Code or Section 10965(f) of the Insurance Code, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan;

h. A qualified employee or dependent loses pregnancy-related coverage described under Section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) and Section 14005.18 of the Welfare and Institutions Code. The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage.

i. A qualified employee or dependent demonstrates to the Exchange, with respect to health plans offered through the Exchange, or to the applicable regulator, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the employee or dependent because he or she was misinformed that he or she was covered under MEC;

j.. A qualified employee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS and as determined by the Exchange on a case-by-case basis, that the individual meets other exceptional circumstances. Such circumstances include, but are not limited to, the following circumstances:
(A) If a child who has been determined ineligible for Medi-Cal and CHIP, and for whom a party other than the party who expects to claim him or her as a tax dependent is required by court order to provide health insurance coverage for the child, the child shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

k. A qualified employee or his or her dependent loses eligibility for pediatric dental coverage subsequent to turning nineteen (19) years of age and wishes to continue dental coverage under a standalone dental plan offered by a QDP in the SHOP.

l. A qualified employee, or his or her dependent, is a victim of domestic abuse or spousal abandonment, is enrolled in MEC, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. A dependent of a victim of domestic or spousal abandonment who is on the same application as the victim may enroll in coverage at the same time as the victim;

m. Applies for coverage on the Exchange during the annual enrollment period, is deemed eligible for Medi-Cal or CHIP, and is deemed ineligible for Medi-Cal or CHIP after open enrollment has ended or more than 60 days after the qualifying event;

n. Applies for coverage with Medi-Cal or CHIP during the annual enrollment period and is deemed ineligible for Medi-Cal or CHIP after open enrollment has ended.

B. A Qualified Employee and/or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they become eligible for assistance, with respect to health insurance coverage under a SHOP, under a Medi-Cal plan (including any waiver or demonstration project conducted under or in relation to such a plan). Receipt of the application for coverage and any supporting documents must be within 60 days of the event. Coverage will become effective on the first day of the month following the loss of coverage.

7. Process of Enrollment

GROUP's application to contract with HEALTH PLAN for coverage of one or more of its Employees will be reviewed by the SHOP for completeness and eligibility. HEALTH PLAN's receipt of transmitted application data of GROUP from the SHOP will constitute the filing of that application with HEALTH PLAN. The SHOP will notify GROUP and its employees of its acceptance and the effective date of coverage for its employees.

The GROUP shall specify the waiting period for coverage in the Employer's Employee Benefit Plan documents, which shall be equally applicable to all Employees and dependents. The waiting period shall not exceed 90 days.

IV. COVERED SERVICES AND BENEFITS

The Evidence of Coverage describes the separate plan(s) of covered services and benefits, as well as excluded benefits, which HEALTH PLAN agrees to provide to GROUP's Enrollees, pursuant to GROUP's choice through SHOP. GROUP understands that one Employee and his or her designated dependents may select one of these plans, and other GROUP Employees and their respective designated dependents may select the same or another of the described benefit plans, but an Employee and his or her designated dependents must all select the same benefit plan, although they may select different medical groups and primary care physicians. The SHOP plans

offered pursuant to the terms of the Agreement and this Supplement are the only benefits which are covered benefits offered by HEALTH PLAN to GROUP through SHOP. HEALTH PLAN itself shall make all benefit and coverage determinations. All such determinations shall be subject to HEALTH PLAN's grievance procedures.

A. Cal-COBRA and COBRA

HEALTH PLAN agrees to provide coverage for GROUP's Cal-COBRA and COBRA-eligible Enrollees at the applicable group rate.

B. Enrollee Materials

HEALTH PLAN shall issue or mail to a new Enrollee an identification card and its Evidence of Coverage booklet provided, however, that only one Evidence of Coverage booklet shall be issued to each Enrollee and his or her dependents, unless the Enrollee or his or her dependent requests an additional Evidence of Coverage booklet be sent. HEALTH PLAN shall be responsible for distributing, or making available for distribution, its federally required Summary of Benefits and Coverage ("SBC"). HEALTH PLAN agrees to provide copies of its Evidence of Coverage, Supplement and SBC to any person requesting such materials, within seven (7) business days of PLAN's receipt of such request. SHOP will post on its website a copy of HEALTH PLAN's current SBC and Evidence of Coverage. HEALTH PLAN agrees to provide to Enrollees and their dependents a copy of its Summary Brochure.

V. FISCAL PROVISIONS

HEALTH PLAN agrees to arrange for the provision of health care services for GROUP's Enrollees, as described in the Evidence of Coverage, in exchange for the Net Premiums received from GROUP less the monies owed to SHOP. HEALTH PLAN agrees to accept the Net Premium due HEALTH PLAN and forwarded to HEALTH PLAN from the SHOP, and any applicable Enrollee co-payments, as full and complete payment for services provided under the Agreement and this Supplement thereto.

A. Premium Collection

1. Premium Payment. GROUP's Premiums for its Enrollees in HEALTH PLAN will be billed to GROUP by the SHOP in a unified billing mechanism which will include itemized Premiums due from GROUP for other SHOP Participating Plans selected by GROUP's Employees.

   a. A Qualified Employer's first premium payment shall be paid in full and must be delivered to the SHOP or postmarked by the due date indicated on the invoice, for effectuation to occur on the date requested on the employer's application.

   b. For on-going premiums, on or about the fifteenth of the month prior to the coverage month, an invoice is sent by the SHOP to GROUP, for which payment must be delivered to the SHOP or postmarked by the last day of the invoicing month. On-going monthly premium payments must be made for the total balance due, by the due date on the invoice to avoid delinquency.

2. Notice of Consequences for Nonpayment of Premiums
   SHOP on behalf of HEALTH PLAN will send a "Notice of Consequence for Nonpayment of Premiums" concurrently with the invoice to GROUP informing GROUP that the group contract may be cancelled or not-renewed if the premium amount due is not received by SHOP.

3. Cancellation for Nonpayment of Premiums. If a billed Premium payment is not received on or before the last day of the month prior to the month of coverage, a "Notice of Start of Grace Period" will be sent via USPS to GROUP by SHOP on behalf of HEALTH PLAN on the first day of that month, identifying the date the 30 day grace period begins and ends, the effective date of cancellation if payment is not received by the end of the grace period, dollar amount past due, and the employer's right to appeal.

   GROUP shall promptly send such Notice to each subscriber receiving coverage under the GROUP's policy.

   The Notice will provide instructions making the premium payment necessary in order to maintain coverage in force and will repeat when such cancellation will be effective and will also state how and when GROUP may appeal the cancellation. If the Premium payment is not received by cancellation effective date, the Agreement will be terminated for non-payment effective 30 days from the date the Notice of Start of Grace Period was sent. In such a case, a "Notice of End of Coverage" will be mailed to GROUP by SHOP on behalf of HEALTH PLAN within 3 days if an electronic notice is sent or 5 business days if a mailed hard copy is sent. PLAN, or SHOP on behalf of HEALTH PLAN, will mail an individual Notice of End of Coverage to each of its affected Members and also explaining their options for purchasing individual coverage.

   All of the notices described above will include statements regarding the reason for the cancellation, the amount of premiums due, a statement of the 30-day grace period, the effective date of the cancellation, and the right of GROUP to seek review by the appropriate regulator, either the California Department of Managed Health Care or the California Department of Insurance (including the responsibility of GROUP to pay premiums during any such review and the right of GROUP to be reinstated back to the effective date of termination if it prevails in such review).

   Receipt by SHOP of all Premium payments due and owing by the due date indicated in the Notice of Start of Grace Period will continue the Agreement, as modified by this Supplement, with no interruption in coverage. If full payment of all delinquent Premiums is not received by SHOP by the due date indicated in the Notice of Start of Grace Period, the Agreement will be terminated.

   GROUP may request to be reinstated in the same coverage in which it was last enrolled within 30 days after the effective date of the termination. Past due premiums, if any, must be paid before the GROUP may be reinstated without a lapse in coverage.

   GROUP may not reinstate coverage 31 or more days following the effective date of termination. GROUP may only reinstate terminated coverage once during the 12-month period beginning on of the original effective date or the most recent renewal date, whichever is more recent.

4. Non-Sufficient Funds
   If a qualified employer makes a premium payment that is returned unpaid for any reason, the SHOP shall apply a $25.00 insufficient funds fee. If a qualified employer makes a second premium payment that is returned unpaid for any reason within six months of the prior returned payment, the qualified employer shall submit premium payment and the insufficient funds fee for returned payment in the form of a cashier's check or money order. This requirement to make monthly premium payments in the form of a cashier's check or money order shall continue for a period of 12 months beginning with the first of the month following the last paid-through date. If premium

payment is not submitted in one of these two forms, the qualified employer group may be subject to termination for non-payment of premium as described in 10 CCR § 6538 (c)(2). In no event shall the failure to pay the insufficient funds fee be a basis to terminate, non-renew or cancel coverage pursuant to Health and Safety Code Section 1365 or Insurance Code Section10273.4, as applicable.

5. GROUP Liable for Premiums During Grace Period. During the grace period described in the preceding paragraphs, the Agreement, as modified by this Supplement, shall continue in force, and GROUP shall be liable for the payment of all Premiums accruing during the grace period.

6. Issuance of New Contract. Following cancellation for nonpayment of Premiums, the current Agreement will not be reinstated. Instead, GROUP must submit a new application for coverage.

7. Delinquent Accounts: Collections: In the event GROUP's account becomes delinquent, SHOP shall undertake collections per State Accounting Manual (SAM) Section 8776.6 (non-employee accounts receivable).

B. Premium Rates

HEALTH PLAN's premium rates are guaranteed for twelve (12) months from the initial enrollment date of the Supplement, which shall be the effective date of the Supplement, and from each subsequent anniversary renewal date thereof. Renewal increases will be based on HEALTH PLAN's "new business" rates in effect on the anniversary date of the Supplement effective date with GROUP.

VI. VOLUNTARY TERMINATION, RENEWAL AND OTHER CHANGES

A. Termination by GROUP

Group may terminate this Agreement at the end of each month. The last day of coverage shall be the end of the month in which the GROUP provided notice of termination, if the GROUP provides notice to the SHOP on or before the fifteenth of the month, or on a case-by-case basis an earlier date upon agreement between the HEALTH PLAN and the SHOP. If the GROUP does not provide notice to the SHOP on or before the fifteenth of the month, the last day of the month following the month in which the GROUP gave notice of termination, or on a case-by-case basis an earlier date upon agreement between the HEALTH PLAN and the SHOP.

B. Termination by Enrollee

An Enrollee may terminate his or her coverage at the end of each month by providing GROUP with written notice of such intent to terminate up to the last day of the month in which the termination is to be effective. An Enrollee's coverage will terminate on the last day of the month in which the written notice is received or on a later date requested by the Enrollee as long as that date is the last day of the month. GROUP to notify SHOP of enrollee's termination request upon receipt of that request.

The coverage of an Enrollee terminating employment with GROUP or losing eligibility for coverage shall extend through the last day of the month in which his or her employment terminated, or such eligibility was lost. GROUP must inform the SHOP within 30 days after the date of termination of coverage of an Enrollee and/or his or her dependents.

C. Annual Enrollment and Renewal

SHOP will send GROUP a renewal package 60 days in advance of the end of the GROUP's current plan year. The renewal package will consist of the QHPs available to the GROUP, changes to current QHPs, and the rates for the following plan year.

If GROUP wishes to renew its coverage through SHOP upon the anniversary date of the Agreement, GROUP must meet the minimum contribution and participation requirements in Section II.A above. If GROUP does not meet such minimum contribution and minimum participation requirements, GROUP may only enroll with HEALTH PLAN through SHOP from November 15th through December 15th of each year.

1. GROUP may only make changes to reference plan during the renewal period.
2. If employee does not enroll in a different QHP during his or her annual employee open enrollment period, the employee will remain in the QHP selected in the previous year unless the employee notifies employer to terminate his or her coverage from the QHP.
3. If the Qualified Employee's current QHP is not available, the employee shall be enrolled in a QHP offered by the same HEALTH PLAN at the same metal tier that is the most similar to the Qualified Employee's current QHP, as determined by the SHOP on a case-by-case basis.
    a. If the HEALTH PLAN of the QHP in which the Qualified Employee is currently enrolled is no longer available, or if another QHP is not available from the current insurance carrier in the same metal tier, the Qualified Employee may be enrolled in the lowest cost QHP offered by a different Health Plan in the same metal tier as the Qualified Employee's current QHP, as determined by the SHOP on a case-by-case basis.

D. Open Enrollment

HEALTH PLAN, through SHOP, will provide a period of at least ten (10) days for the annual employer election period and at least twenty (20) days for employee annual open enrollment period prior to the anniversary date of the Agreement, with such requested changes to be effective on such anniversary date. During the employer election period, the employer may change its offering of dependent coverage, its contribution level to employee coverage, and level of coverage within which its employees and dependents can select a QHP.

1. Enrollees electing to make open enrollment changes shall provide the Change Form to their employer for submission to the SHOP prior to 1st of the renewal month.
2. Enrollees Open Enrollment changes submitted to SHOP during the first thirty (30) days of the new plan year are only permitted to make changes within the same Health Plan.
    a. Requests to the SHOP received on the first through the fifteenth day of the month after effective date shall become retroactively effective to the first day of the month, unless the employer requests an effective date of the first of the following month.
    b. Requests to the SHOP received on the sixteenth day of the month up to the thirtieth day of the month after effective date shall become effective on the first day of the following month.

E. Discontinued Group's Reference Plans

If GROUP's reference plan is no longer available, GROUP must select a new reference plan during the annual election period. If GROUP fails to select a reference plan a default alternative reference plan will be auto-selected for the GROUP in accordance with 10 CCR section 6526.

F. Miscellaneous

1. Enrollees may not change plan benefit levels within HEALTH PLAN, if GROUP has made such option available, other than during the open enrollment period.
2. An Eligible Employee of GROUP who, at the time GROUP initially enters into the Agreement, as modified by this Supplement, had declined coverage through the SHOP and who did not have coverage from another source at that time must wait to enroll until the next open enrollment period unless he or she experiences a special enrollment qualifying event in the interim.

Kaiser Foundation Health Plan, Inc.
Northern and Southern California Regions

A nonprofit corporation

Group Agreement for
COVERED CALIFORNIA FOR SMALL BUSINESS

Group IDs: 799999 and 399999

Contract Year 2023

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Introduction

This Group Agreement (*Agreement*), including the Covered California for Small Business (CCSB) Program Supplement Rider (*Supplement*) and the *Evidence of Coverage* (*EOC*) document(s) listed below under "Health Plan and Other Ancillary Products," the group application that Group submitted to CCSB, and any amendments to any of them, all of which are incorporated into this *Agreement* by reference, constitute the contract between Kaiser Foundation Health Plan, Inc., (Health Plan), CCSB, and Group.

If Group has applied for Ancillary Coverage through Health Plan, provided under a separate contract, it is the intent of Group and Health Plan that coverage under this Agreement and those other contract(s) be treated as one package of benefits for the purposes of term, renewal, termination and payment of Premiums.

In consideration of timely payment of Premium, Health Plan will provide or arrange for covered Services to Members in accord with the documents listed below under "Health Plan and Other Ancillary Products."

Health Plan and Other Ancillary Products

Health Plan products, including Ancillary Coverage offered by Health Plan

Product name	*EOC #*
Kaiser Permanente Platinum 90 HMO 0/20 + Child Dental	1
Kaiser Permanente Gold 80 HMO 250/35 + Child Dental	2
Kaiser Permanente Silver 70 HMO 2500/55 + Child Dental	3
Kaiser Permanente Bronze 60 HDHP HMO 7000/0 + Child Dental	5
Kaiser Permanente Bronze 60 HMO 6300/65 + Child Dental	6
Kaiser Permanente Silver 70 HMO 1900/65 + Child Dental Alt	74
Kaiser Permanente Platinum 90 HMO 0/10 + Child Dental Alt	97
Kaiser Permanente Chiropractic/Acupuncture Plan-$15 Copay/20 Visits	98
Kaiser Permanente Platinum 90 HMO 0/20 + Child Dental INF	121
Kaiser Permanente Gold 80 HMO 250/35 + Child Dental INF	122
Kaiser Permanente Silver 70 HMO 2500/55 + Child Dental INF	123
Kaiser Permanente Bronze 60 HDHP HMO 7000/0 + Child Dental INF	124
Kaiser Permanente Bronze 60 HMO 6300/65 + Child Dental INF	125
Kaiser Permanente Silver 70 HMO 1900/65 + Child Dental Alt INF	127
Kaiser Permanente Platinum 90 HMO 0/10 + Child Dental Alt INF	128
Kaiser Permanente Silver 70 HDHP HMO 2700/25% + Child Dental	129
Kaiser Permanente Silver 70 HDHP HMO 2700/25% + Child Dental INF	130
Kaiser Permanente Silver 70 HMO 2300/65 + Child Dental Alt	241
Kaiser Permanente Silver 70 HMO 2300/65 + Child Dental Alt INF	242
Kaiser Permanente Gold 80 HMO 0/30 + Child Dental Alt	265
Kaiser Permanente Gold 80 HMO 0/30 + Child Dental Alt INF	266
Kaiser Permanente Gold 80 HMO 1000/40 + Child Dental Alt	267
Kaiser Permanente Gold 80 HMO 1000/40 + Child Dental Alt INF	268
Kaiser Permanente Silver 70 HMO 2800/65 + Child Dental Alt	269
Kaiser Permanente Silver 70 HMO 2800/65 + Child Dental Alt INF	270
Kaiser Permanente Bronze 60 HMO 5400/60 + Child Dental Alt	271
Kaiser Permanente Bronze 60 HMO 5400/60 + Child Dental Alt INF	272
Kaiser Permanente Gold 80 HDHP HMO 1600/15% + Child Dental Alt	361
Kaiser Permanente Gold 80 HDHP HMO 1600/15% + Child Dental Alt INF	362

Pediatric dental coverage

Product name	Bundled with EOC #
DeltaCare USA Group Dental Service Contract*	1
DeltaCare USA Group Dental Service Contract*	2
DeltaCare USA Group Dental Service Contract*	3
DeltaCare USA Group Dental Service Contract*	5
DeltaCare USA Group Dental Service Contract*	6
DeltaCare USA Group Dental Service Contract*	74
DeltaCare USA Group Dental Service Contract*	97
DeltaCare USA Group Dental Service Contract*	121
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*Group has applied for the following product that is provided under a separate contract. When coverage is issued through more than one contract, it is the intent of Group and Health Plan that coverage under this *Agreement* and that other contract be treated as one package of benefits for the purposes of term, renewal, termination and payment of premiums:

- Group has applied for DeltaCare USA Group Dental Service Contract (Delta Dental Contract) through a package offered through Health Plan. Benefits offered through the Delta Dental Contract are underwritten by Delta Dental of California and administered by Delta Dental Insurance Company. Please refer to the attached Delta Dental Contract for information about dental plan benefits.

Other Ancillary Coverage

Not applicable

In this *Agreement,* some capitalized terms have special meaning; please see the "Definitions" section in the *EOC* documents for definitions of terms that are used in *EOC* documents and this *Agreement*.

Term of *Agreement* and Renewal

Term of *Agreement*

Unless terminated as set forth in the "Termination of *Agreement"* section, this *Agreement* is effective for contract year 2023 (that 12-month contract period beginning with your Group's renewal date in 2023), unless amended. If your Group's renewal date is not January 1st, this *EOC* is applicable during that 12-month contract period beginning with your Group's renewal date in 2023.

Renewal

This *Agreement* does not automatically renew. If Group complies with all of the terms of this *Agreement*, Health Plan will provide prior written notice of any offer to renew the *Agreement*, in a timely manner consistent with applicable state and federal requirements, by doing one of the following:

- Providing Group with a new *Group Agreement* to become effective immediately after termination of this *Agreement*
- Extending the term of this *Agreement* and making other changes pursuant to "Amendments Effective on your Group's Anniversary Date" in the "Amendment of *Agreement*" section

Health Plan will provide Group a renewal notice, which will include a summary of changes to this *Agreement.* The new or extended-term *Group Agreement* will incorporate the changes summarized in the renewal notice. Health Plan will issue to Group the new or extended-term Group Agreement after Group confirms its intent to renew coverage, or 60 days after Group's Anniversary Date if Group does not provide affirmative confirmation of its intent to renew coverage prior to that date.

If Group does not want to renew the *Agreement*, Group must give Health Plan written notice as described under "Termination on Notice" or "Termination due to Nonacceptance of Amendments" in the "Termination of *Agreement*" section.

Coverage of dental services benefits under the Delta Dental Contract attached to this *Agreement* will automatically renew upon the renewal of this *Agreement*.

Note: Your Group's Anniversary Date is the date that your Group's contract renews each year. For example, if this contract renews on January 1, 2022, your Group's Anniversary Date is January 1.

Amendment of *Agreement*

Amendments Effective on your Group's Anniversary Date

Upon 60 days prior written notice to Group, Health Plan may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective on your Group's Anniversary Date. Your Group's Anniversary Date is the date that your Group's contract renews each year. For example, if this contract renews on January 1, 2022, your Group's Anniversary Date is January 1.

Amendments Related to Government Approval

If Health Plan notified Group that Health Plan had not received all necessary governmental approvals related to this *Agreement*, Health Plan may amend this *Agreement* by *giving* written notice to Group after receiving all necessary governmental approvals. Any such government-approved provisions go into effect on your Group's Anniversary Date in 2023 (unless the government requires a later effective date). Your Group's Anniversary Date is the date that your Group's

contract renews each year. For example, if this contract renews on January 1, 2022, your Group's Anniversary Date is January 1).

Amendment Due to Tax or Other Charges

If a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Health Plan or Plan Providers (or any of their activities), then upon 60 days prior written notice, Health Plan may increase Group's Premiums to include Group's share of the new or increased tax or charge. Group's share will be determined by dividing the number of Members enrolled through Group by the total number of members enrolled in Health Plan's Northern California Region.

Other Amendments

Health Plan may amend this *Agreement* at any time by giving written notice to Group, in order to address any law or regulatory requirement, which may include an increase in Premiums to reflect an increase in costs to Health Plan or Plan Providers (Health Plan will give Group 60 days prior written notice of any increase in Premiums or reduction in benefits), or ensure that the deductible amount in any High Deductible Health Plan *EOC* continues to meet the U.S. Department of Treasury's minimum deductible amount required in High Deductible Health Plans.

Acceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 15 days after the date of Health Plan's amendment notice, in which case this *Agreement* will terminate pursuant to "Termination due to Nonacceptance of Amendments" in the "Termination of *Agreement*" section.

Termination of *Agreement*

This *Agreement* will terminate under any of the conditions listed below. All rights to benefits under this *Agreement* end on the termination date, except as expressly provided in the "Termination of Membership" or "Continuation of Membership" sections of an *Evidence of Coverage*. The termination date is the first day when this *Agreement* is no longer in effect (for example, if the termination date is January 1, 2024, the last minute this *Agreement* was in effect was at 11:59 p.m. on December 31, 2023).

If Health Plan terminates this *Agreement,* Health Plan will give Group written notice. In the case of "Termination for Nonpayment", "Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information", and "Termination for Discontinuance of a Product or all Products within a Market," Health Plan will provide both advance notice of the termination in addition to a final notice of termination. Within five business days of receipt of an advance or final notice of termination, Group will provide each Subscriber a legible copy of the notice and will give Health Plan proof of that notice was provided including the date thereof.

Coverage of dental services benefits under the Delta Dental Contract attached to this *Agreement* will automatically terminate upon the termination of this *Agreement*.

Termination on Notice

Group may terminate this Agreement effective as of the Anniversary Date by giving prior written notice to Health Plan at least 30 days prior to the Anniversary Date, except that termination will be effective as of the first of the month following the Anniversary Date if the Anniversary Date is not the first of the month. Group remains responsible for remitting all amounts payable relating to this Agreement, including Premiums, for the period through the termination date.

Termination Due to Nonacceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 15 days after the date of Health Plan's amendment notice and remits all amounts payable related to this *Agreement*, including Premiums, for the period prior to the amendment effective date. This *Agreement* will terminate the day before the effective date of the amendment.

Termination for Nonpayment

Premiums are due for the Full Premium owed as described in the "Premiums" section. If Health Plan does not receive the required Premium payment for all coverage issued under this *Agreement* on or before the due date, we will provide a notice of start of grace period to Group as described under "Notices" in the "Miscellaneous Provisions" section. This notice will include the following information:

- A statement that we have not received Full Premium payment and that we will terminate this *Agreement* for nonpayment if we do not receive the required Premiums by the specified date
- The amount of Premiums past due

If we do not receive the required Premiums by the date indicated in the notice of start of grace period, the *Agreement* will terminate and all coverage issued under the *Agreement* will end on the date specified in the notice of start of grace period, which will be at least 30 days after the date of the notice. The *Agreement* will remain in effect during this grace period, but upon termination Group will be responsible for paying all past due Premiums, including the Premiums for coverage provided during this grace period.

We will provide notice of termination to Group as described under "Notices" in the "Miscellaneous Provisions" section if we do not receive Full Premium payment within 30 days after the date of the notice of start of grace period.

Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information

If Group commits fraud or intentionally furnishes incorrect or incomplete material information to Health Plan, Health Plan may terminate this *Agreement* upon 30 days prior written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

Termination for Violation of Contribution or Participation Requirements

If Group fails to comply with Health Plan's participation or contribution requirements (including those discussed in the "Contribution and Participation Requirements" section), Health Plan may terminate this *Agreement* upon 30 days prior written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

Termination for Discontinuance of a Product or all Products within a Market

Grandfathered products

Health Plan may terminate a particular product or all products offered in a small or large group market as permitted or required by law. If Health Plan discontinues offering a particular grandfathered product in a market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days prior written notice to Group. Health Plan will offer Group another product that it makes available to groups in the small or large group market, as applicable. If Health Plan discontinues offering all products to groups in a small or large group market, as applicable, Health Plan may terminate this *Agreement* upon 180 days prior written notice to Group and Health Plan will not offer any other product to Group. A "product" is a combination of benefits and services that is defined by a distinct *Evidence of Coverage*.

All other products

Health Plan may terminate a particular product or all products offered in the group market as permitted or required by law. If Health Plan discontinues offering a particular product (other than a grandfathered product) in the group market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days prior written notice to Group. Health Plan will offer Group another product that it makes available in the group market. If Health Plan discontinues offering all products in the group market, Health Plan may terminate this *Agreement* upon 180 days prior written notice to Group and Health Plan will not offer any other product to Group. A "product" is a combination of benefits and services that is defined by a distinct *Evidence of Coverage*.

Contribution and Participation Requirements

No change in Group's contribution or participation requirements listed below is effective for purposes of this *Agreement* unless Health Plan consents in writing. As a condition to consenting to Group's revised contribution and participation requirements, Health Plan may require Group to agree to amend the Premiums, benefits, or other provisions of this *Agreement*.

Group must:

- Contribute to all health care coverage available through Group on a basis that does not financially discriminate against Health Plan or against people who choose to enroll in Health Plan
- For each Family, Group's contribution must be no less than 50 percent of the Premiums required for the lowest-priced Kaiser Permanente medical plan offered by your Group
- Ensure that:
  - all employees enrolled in Health Plan must meet the definition of "eligible employee" in Section 1357.500 or 1357.600 of the California Health and Safety Code
  - all employees enrolled in Health Plan are covered by workers' compensation or the employer's liability benefits, unless not required by law to be covered
  - at least 50 percent of eligible employees are covered by a group health care plan
  - at least one active employee is enrolled under this *Agreement*
  - all Subscribers live or work inside the Service Area applicable to their coverage when they enroll
- Meet all applicable legal and contractual requirements, such as:
  - meet and continue to meet the definition of "small employer" or "guaranteed association" in Section 1357.500 or 1357.600 of the California Health and Safety Code
  - for Groups enrolled as guaranteed associations, meet and continue to meet all legal requirements applicable to guaranteed associations
  - elect any coverage that Group is required by law to provide
  - distribute disclosures about coverage as described under "Member Information" in the "Miscellaneous Provisions" section
  - adhere to all requirements set forth in the applicable *Evidence of Coverage*
  - obtain Health Plan's prior written approval of any Group eligibility requirements that are not stated in the applicable *Evidence of Coverage*
  - use Member enrollment application forms that are provided or approved by Health Plan
  - offer enrollment in accord with eligibility requirements in state law (for example, domestic partners must be eligible if married spouses are eligible and disabled dependents must be eligible if dependent children are eligible)
- Offer enrollment in Health Plan to all eligible people on conditions no less favorable than those for any other health care plan available through Group

- Upon request, provide Health Plan with documentation that proves each Subscriber is an eligible employee, proprietor, or partner. Also, Group must provide, upon request, documentation that demonstrates to Health Plan's satisfaction that Group is complying with all contribution and participation requirements

Miscellaneous Provisions

Assignment

Health Plan may assign this *Agreement*. Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Health Plan's prior written consent. This *Agreement* shall be binding on the successors and permitted assignees of Health Plan and Group.

Attorney Fees and Costs

If Health Plan or Group institutes legal action against the other to collect any sums owed under this *Agreement*, the party that substantially prevails will be reimbursed for its reasonable litigation expenses, including attorneys' fees, by the other party.

Confidential Information about Health Plan or its Affiliates

For the purposes of this "Confidential Information about Health Plan or its Affiliates" section, "Confidential Information" means any oral, written, or electronic information concerning Health Plan or its affiliates, if the information either is marked "confidential" or is by its nature proprietary or non-public, except that it does not include any of the following:

- Information that is or becomes available to the public other than as a result of disclosure by Group or its employees, advisors, or representatives
- Information that was available to Group or within its knowledge before Health Plan disclosed it to Group
- Information that becomes available to Group from a source other than Health Plan, but only if that source is not bound by a confidentiality agreement with Health Plan

If Group receives any Confidential Information, it will use that information only to evaluate Health Plan and actual or proposed group agreements with Health Plan. Group will ensure that the information is not disclosed to anyone other than a limited number of Group's employees and advisors, and only to the extent necessary in connection with the evaluation of Health Plan and actual or proposed group agreements with Health Plan. Group will inform any such employees and advisors that the information is confidential and that they must treat it confidentially.

Upon Health Plan's request Group will promptly return to Health Plan all Confidential Information, and will destroy any other copies and any notes or other Group documents about the information.

If Group is requested or required (by oral questions, interrogatories, request for information or documents, subpoena, civil investigative demand, or similar process) to disclose any Confidential Information, Group will give Health Plan prompt notice of the request or requirement, and Group will cooperate with Health Plan in seeking to legally avoid the disclosure. If, in the absence of a protective order, Group is legally compelled, in the opinion of its counsel, to disclose any of the information, Health Plan either will seek and obtain appropriate protective orders against the disclosure or will be deemed to waive Group's compliance with the provisions of this "Confidential Information about Health Plan or its Affiliates" section to the extent necessary to satisfy the request or requirement.

Group understands (and will inform any employees and advisors who receive Confidential Information) that United States securities laws prohibit anyone who has material non-public information about a company from buying or selling that company's securities in reliance upon that information or from communicating the information to any other person or entity under circumstances in which it is reasonably foreseeable that the person or entity is likely to buy or sell that company's

securities in reliance upon the information. Group agrees that it and its affiliates, associates, employees, agents, and advisors will not rely on any Confidential Information in directly or indirectly buying or selling any Health Plan securities.

Monetary damages would not be a sufficient remedy for any breach or threatened breach of this “Confidential Information about Health Plan or its Affiliates” section. Health Plan will be entitled to equitable relief by way of injunction or specific performance if Group or any of its officers, directors, employees, attorneys, accountants, agents, advisors, or representatives breach, or threaten to breach, any of the provisions of this “Confidential Information about Health Plan or its Affiliates” section.

Group’s obligations under this “Confidential Information about Health Plan or its Affiliates” section will continue indefinitely and will survive the termination or expiration of this *Agreement.*

Contract Providers

Health Plan will give Group written notice within a reasonable time of any termination or breach of contract by, or inability to perform of, any health care provider that contracts with Health Plan if Group may be materially and adversely affected thereby.

Delegation of Claims Review

Group delegates to Health Plan the discretion to determine whether a Member is entitled to benefits under this *Agreement*. In making these determinations, Health Plan has discretionary authority to review claims in accord with the procedures contained in this *Agreement* and to construe this *Agreement* to determine whether the Member is entitled to benefits. If coverage under an *EOC* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), Health Plan is a “named claims fiduciary” to review claims under that *EOC*.

Electronic Delivery of Written Communications, Contracts, and Other Documents

Written communications, contracts, and other documents may be provided electronically to Group, as allowed by law. If provided by posting to an electronic system, Health Plan will inform Group when a document is available for retrieval. A communication or document that is sent electronically shall be deemed received when the Group is able to retrieve the electronic communication or document from the electronic or information processing system designated for the purpose of receiving electronic records or information of the type sent. Communications and documents that may be delivered electronically include this *Agreement*, the annual renewal notice, and other communications between Group and Health Plan as allowed by law to be delivered electronically. A notice of termination will not be delivered electronically.

Group may opt-out of electronic delivery of communications and documents at any time by providing notice to Health Plan.

Enrollment Application Requirements

Group must use enrollment application forms that are provided by Health Plan. If Group wants to use a different form or system for enrolling Members, Group must obtain Health Plan’s prior approval of the form or system. Other forms and systems include a “universal” enrollment application form, interactive voice recording (IVR) enrollment system, or intranet online enrollment system. All forms and systems must meet Health Plan requirements for enrolling Members, including disclosure of binding arbitration in accord with Section 1363.1 of the California Health and Safety Code and other applicable law. Group must retain documentation of each Member’s acceptance of the use of binding arbitration indefinitely, and upon request, must be able to produce documentation relating to a specific Member to Health Plan at any time. In the event that the contract between Health Plan and Group terminates or Group is unable to comply with this document retention requirement, Group must transfer possession of all such documentation to Health Plan in a mutually agreeable manner. Group’s Kaiser Permanente representative can provide Group with Health Plan’s current requirements for enrollment application forms and systems.

Grandfathered Health Plan Coverage

For any coverage identified in an EOC as a "grandfathered health plan" under the Patient Protection and Affordable Care Act and regulations, Group must immediately inform Health Plan if this coverage does not meet (or no longer meets) the requirements for grandfathered status including but not limited to any change in its contribution rate to the cost of any grandfathered health plans during the plan year. Group represents that, for any coverage identified as a "grandfathered health plan" in the applicable *EOC*, Group has not decreased its contribution rate more than five percent (5%) for any rate tier for such grandfathered health plan when compared to the contribution rate in effect on March 23, 2010 for the same plan. Health Plan will rely on Group's representation in issuing and continuing any and all grandfathered health plan coverage.

Governing Law

Except as preempted by federal law, this *Agreement* will be governed in accord with California law and any provision that is required to be in this *Agreement* by state or federal law, shall bind Group and Health Plan whether or not set forth in this *Agreement*.

Member Information

Group will inform Members and prospective Members of eligibility requirements for Subscribers and Dependents and when coverage becomes effective and terminates.

When Health Plan notifies Group about changes to this *Agreement* or provides Group other information that affects Members, Group will disseminate the information to Members by the next regular communication to them, but in no event later than 30 days after Group receives the information.

For each Health Plan coverage included in this *Agreement*, Health Plan will provide Group with the following disclosures for Group to distribute in accord with applicable laws ("Member Materials"):

- A *Disclosure Form* (*DF*) for each non-Medicare coverage. Group will provide *DFs* (or combined *EOC/DFs*) to Subscribers and potential Subscribers when the coverage is offered
- A *Summary of Benefits and Coverage* (*SBC*) for each non-Medicare coverage other than retiree plans with fewer than two current employees. Group will provide electronic or paper *SBCs* to Members and potential Members to the extent required by law, except that Health Plan will provide *SBCs* to Members who make a request to Health Plan
- An *EOC* for each non-Medicare coverage. Group will provide *EOCs* (or combined *EOC/DFs*) to Subscribers, except that Health Plan will provide *EOCs* (or combined *EOC/DFs*) to Members and potential Members who make a request to Health Plan

If Group receives the *Agreement* or Member Materials in electronic form, Group is not authorized to modify or alter in any way the text or the formatting of the electronic *Agreement* or Member Materials.

Health Plan assumes no responsibility for any changes in text or formatting that may occur in the *Agreement* or Member Materials after they are provided to Group. If Group posts the electronic *Agreement* or Member Materials on its intranet site, it shall do so in such a way so as to permit employees of Group to download and print a complete and accurate copy of the *Agreement* or Member Materials.

In the event Health Plan reasonably concludes that Group is either using the electronic *Agreement* or Member Materials in a manner not permitted by this *Agreement* or is not providing Subscribers with access to the Member Materials in accord with applicable laws, then Health Plan will print copies of the *Agreement* or Member Materials and Group will cooperate with Health Plan to ensure that printed copies of the *Agreement* or Member Materials are provided in a timely manner to all employees of Group enrolled with Health Plan. Group agrees to reimburse Health Plan for the reasonable cost of printing and delivering the *Agreement* or Member Materials.

No Waiver

Health Plan's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision, or impair Health Plan's right thereafter to require Group's strict performance of any provision.

Notice

Notice under this Agreement shall be in writing and is deemed given when delivered in person or deposited in the U.S. mail. Notice may also be provided by email if Group has furnished its email address as part of its address of record, and as allowed by law. Health Plan or Group may change its addresses, or email address, for notices by giving written notice to the other.

Notices from Health Plan to Group will be sent to:

Covered California for Small Business
P.O. Box 7010
Newport Beach, CA 92658

Notices from Group to Health Plan will be sent to:

Kaiser Permanente
California Service Center
P.O. Box 23219
San Diego, CA 92193-3219

Open Enrollment

Group must hold an annual open enrollment period during which all eligible people, in accord with state law, may enroll in Health Plan or in any other health care plan available through Group. Also, Group must not hold open enrollment for 2024 until Group receives its 2024 group agreement Premium and coverage information from Health Plan. If Group holds the open enrollment without receiving 2024 group agreement Premium and coverage information, Health Plan may change Premiums and coverage (including benefits and Cost Sharing) when it offers to renew Group's Agreement as described under "Renewal" in the "Term of Agreement and Renewal" section.

Other Group coverage that covers Essential Health Benefits

For each non-grandfathered non-Medicare Health Plan coverage, except for any retiree-only coverage, Group must do all of the following if Group provides Health Plan Members with other medical or dental coverage (for example, separate pharmacy coverage) that covers any Essential Health Benefits:

- Notify Health Plan of the out-of-pocket maximum (OOPM) that applies to the Essential Health Benefits in each of the other medical or dental coverage.
- Ensure that the sum of the OOPM in Health Plan's coverage plus the OOPMs that apply to Essential Health Benefits in all of the other medical and dental coverage does not exceed the annual limitation on cost sharing described in 45 CFR 156.130.

Representation regarding communication of membership changes

Group represents that its communication regarding membership changes to Health Plan is accurate. Group and its representative are bound by all membership data, including any changes or updates that it, or its representative, submits to Health Plan via any medium, electronic or otherwise, including but not limited to the following:

- Electronic data submissions regarding enrollment and eligibility
- Health Plan approved online tool for submission of data
- Paper enrollments submitted through postal mail or fax

Health Plan's Administrative Handbook includes the details about how to report membership changes. Group's Kaiser Permanente representative can provide Group with an Administrative Handbook if Group does not have one.

Representation Regarding Waiting Periods

By entering into this Agreement, Group hereby represents that Group does not impose a waiting period exceeding 90 days on employees who meet Group's eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll in non-Medicare coverage under the terms of a group health plan can become effective in accord with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

In addition, Group represents that eligibility data provided by the Group to Health Plan will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations and will not exceed the waiting period established by Group. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: Because the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Right to Examine Records

Upon reasonable notice, Health Plan may examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement***.**

Social Security and Tax Identification Numbers

Within 60 days after Health Plan sends Group a written request, Group will send Health Plan a list of all Members covered under this Agreement, along with the following:

- The Social Security number of the Member
- The tax identification number of the employer of the Subscriber in the Member's Family
- Any other information that Health Plan is required by law to collect

Premiums

Only Members for whom Health Plan (or its designee) has received the Full Premium payment as described below are entitled to coverage under this *Agreement*, and then only for the period for which Health Plan (or its designee) has received required Premium payment. Group is responsible for paying Premiums, except that Members who have Cal-COBRA coverage under an *EOC* that is included in this *Agreement* are responsible for paying Premiums for Cal-COBRA coverage.

Premiums due under this *Agreement* include premiums for dental services underwritten by Delta Dental of California, as described in the attached Delta Dental Contract.

Due Date and Payment of Premiums

The payment due date for each enrollment unit (or subgroup) associated with Group will be reflected on the monthly membership invoice if applicable to Group (if not applicable, then as specified in writing by Health Plan). If Group does not pay Full Premiums by the first of the coverage month, the Premiums may include an additional administrative charge upon renewal. "Full Premiums" means 100 percent of monthly Premiums for all of the coverage issued to each enrolled Member, as set forth under "Calculating Premiums" in this "Premiums" section.

New Members

Premiums are payable for a new Member for the entire month when the Member's coverage effective date is any day during that month.

Note: Membership begins at the beginning (12:00 a.m.) of the effective date of coverage.

Membership Termination

Premiums are payable for the entire month for a Member whose last day of coverage is any day during that month.

Note: The membership termination date is the first day a Member is not covered (for example, if the termination date is January 1, 2024, the last minute of coverage was at 11:59 p.m. on December 31, 2023).

Premium Rebates

If state or federal law requires Health Plan to rebate premiums from this or any earlier contract year and Health Plan rebates premiums to Group, Group represents that Group will use that rebate for the benefit of Members, in a manner consistent with the requirements of the Public Health Service Act and the Affordable Care Act and if applicable with the obligations of a fiduciary under the Employee Retirement Income Security Act (ERISA).

Calculating Premiums

To calculate the amount of Full Premiums that apply to a Family, first determine whether the Family is enrolled under a grandfathered plan or a metal tier plan (metal tier plans have "Platinum," "Gold," "Silver," or "Bronze" in the plan name):

- If the Family is enrolled under a grandfathered plan, follow the steps under "Rate rules for grandfathered coverage" below
- If the Family is enrolled under a metal tier plan, follow the steps under "Rate rules for metal tier coverage" below

Rate rules for grandfathered coverage

To calculate the amount of Full Premiums that apply to a Family (a Subscriber and all of their Dependents):

1. For the medical plan, identify Premiums in the applicable table below based on the age of the Subscriber and the family role type of each Member (see the "Definitions" section of the EOC for the definition of Subscriber, Dependent, and Spouse). If there are more than one dependent children under age 26, then no extra premium cost is applied to the second or more children.
2. If the Family has any Ancillary Coverage (chiropractic, acupuncture, and dental coverage), identify the Premiums based on the family role type of each Member. If Ancillary Coverage has been issued under a separate contract and Premiums for that coverage are not listed in the tables below, refer to that contract for Premiums. This Ancillary Coverage is part of the contract options selected by Group, and Group submits payment for this Ancillary Coverage as part of Full Premiums. If there are more than one dependent children under age 26, then no extra premium cost is applied to the second or more children.
3. For each member of the Family, add the amount of Premiums for medical and Ancillary Coverage together to arrive at the total, Full Premiums required for the Family.

Rate rules for metal tier coverage

To calculate the amount of Full Premiums that apply to a Family (a Subscriber and all of their Dependents):

1. For the medical plan, identify the Premiums in the applicable table below based on each Member's age. For Dependent children under age 26, the following applies:
   - **Children under age 21:** Include Premiums for no more than three children (additional Dependent children under age 21 are covered at no additional Premium).
   - **Children age 21 to 25:** Include Premiums for all children.
2. If the Family has family dental coverage, identify the Premiums based on the family role type of each Member (see the "Definitions" section of the EOC for the definition of Subscriber, Dependent, and Spouse). If the family dental coverage has been issued under a separate contract and Premiums for that coverage are not listed in the Premium tables below, refer to that contract for Premiums. This family dental coverage is part of the contract options selected by Group, and Group submits payment for this family dental coverage as part of Full Premiums.
3. For each member of the Family, add the amount of Premiums for medical and family dental coverage together to arrive at the total, Full Premiums required for the Family.

Delta Dental Contract

For information about pediatric dental coverage, please refer to the Delta Dental Contract attached to this *Agreement*.

Agreement Signature Page

Acceptance of *Agreement*

Group acknowledges acceptance of this *Agreement* by signing the Signature Page and returning it to Health Plan. If Group does not return it to Health Plan, Group will be deemed as having accepted this *Agreement* if Group pays Health Plan any amount toward Premiums.

Group may **not** change this *Agreement* by adding or deleting words, and any such addition or deletion is void. Health Plan might not respond to any changes or comments submitted on or with this Signature Page. Group may not construe Health Plan's lack of response to any submitted changes or comments to imply acceptance. If Group wishes to change anything in this *Agreement*, Group must contact its Kaiser Permanente representative. Health Plan will issue a new *Agreement* or amendment if Health Plan and Group agree on any changes.

A signature on this *Agreement* serves to bind Group to the dental coverage underwritten by Delta Dental of California, as described in the attached Delta Dental Contract as though Group had separately executed the Delta Dental Contract.

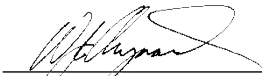
Binding Arbitration

As more fully set forth in the arbitration provision in the applicable *Evidence of Coverage*, disputes between Members, their heirs, relatives, or associated parties (on the one hand) and Health Plan, Kaiser Permanente health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising out of or related to this *Agreement*, including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this *Agreement*, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Members enrolled under this *Agreement* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the applicable *Evidence of Coverage* except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

Signatures

Kaiser Foundation Health Plan, Inc., Northern and Southern California Regions



Wade J. Overgaard
Authorized officer
Senior Vice President, Health Plan Operations
July 14, 2022

COVERED CALIFORNIA FOR SMALL BUSINESS

____
Authorized Group officer signature

____
Print name and title Date

Please keep this copy of the signature page with your *Agreement*. An extra copy is included in your contract package to sign and return:

- **By mail:** Kaiser Permanente, California Service Center, P.O. Box 23448, San Diego, CA 92193-3448.
- **By fax:** 1-855-355-5334

Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105
800-589-4618

DeltaCare® USA Group Dental Service Contract

INTRODUCTION

The Contractholder named in the Medical Plan Issuer ("MPI") *Group Agreement* applied for a group dental service Contract with Delta Dental of California ("Delta Dental") through a Packaged Offering with the MPI, Kaiser Foundation Health Plan, Inc. ("KFHP"). The following terms will apply:

- Contractholder will pay the MPI or the MPI's third party administrator the monthly Premiums stated in the MPI *Group Agreement*.
- When the Contractholder pays the first month's Premium, the term of this Contract will begin at 12:01 a.m. Pacific Standard Time on the Effective Date shown in the MPI *Group Agreement*. The term of this Contract will end as stated in the MPI *Group Agreement* at the end of the Contract Term at 12:00 a.m. Pacific Standard Time.
- Contractholder will provide each eligible Employee electing coverage under this Contract with electronic access to a *Combined Evidence of Coverage and Disclosure Form* ("EOC") supplied by Delta Dental. Delta Dental will furnish a hard copy to the Enrollee or Contractholder upon request. Contractholder will also distribute to its eligible Employees enrolled under this Contract any notice from Delta Dental which may affect their rights under this Contract.
- Contractholder will provide each eligible Employee with electronic access to a *Summary of Dental Benefits and Coverage Disclosure Matrix* ("SDBC") supplied by Delta Dental at the following web address: https://www1.deltadentalins.com/group-sites/kaiserpediatrics.html.
- Delta Dental's enrollment materials advise eligible persons that an EOC is also available upon request, prior to enrollment, by contacting Delta Dental's Customer Care. A matrix which describes the dental plan's major Benefits and coverage is included at the back of the EOC ("Schedule C").
- The EOC will disclose the terms and conditions of coverage but will constitute only a summary of the dental plan. As required by the California Health and Safety Code, this Contract must be consulted to determine the exact terms and conditions of the coverage provided. A copy of this Contract will be furnished upon request.
- Enrollees should read the EOC carefully. Persons with special health care needs should read the section entitled "Special Health Care Needs."
- Pursuant to California Health and Safety Code, the EOC provides Enrollees with information regarding the societal benefits of organ donation and the method whereby an Enrollee may elect to be an organ or tissue donor. Enrollees may also obtain information about Benefits by calling Delta Dental's Customer Care at 800-589-4618.

So long as Contractholder pays the Premiums as stated in Section 3 and in the MPI *Group Agreement*, Delta Dental agrees to provide the Benefits described in this Contract and the attached EOC.

This Contract is underwritten by Delta Dental of California, administered by Delta Dental Insurance Company and governed by the laws of the state of California in which it is issued and delivered.

Delta Dental of California

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

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SECTION 1 - DEFINITIONS

Terms with capital letters appearing in this Contract shall have the meaning given to them in the attached EOC. In addition, the following terms shall have these meanings:

1.01 Contract - this agreement between Delta Dental and Contractholder including the EOC and any Attachments. This Contract constitutes the entire agreement between the parties.

1.02 Contract Term - the period during which this Contract is in effect as shown in the MPI *Group Agreement*.

1.03 Cost Sharing - the amounts payable (whether denominated copayments, coinsurance or deductibles) by or on behalf of the Enrollee for professional services pursuant to the Delta Dental plan to which the Enrollee is assigned.

1.04 Eligibility Date - the date upon which an Enrollee's eligibility for Benefits becomes effective under the MPI *Group Agreement*.

1.05 Premium - the amounts payable as shown in the *Group Agreement* issued by the MPI.

SECTION 2 - DUTIES OF DELTA DENTAL

2.01 Delta Dental shall provide the Benefits in the attached EOC, subject to the limitations and exclusions in the Schedules attached to the EOC. Benefits are available to each Enrollee on the Eligibility Date.

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

2.02 Delta Dental shall provide Enrollees with Contract Dentists at convenient locations during the term of this Contract. Upon enrollment, Delta Dental will assign the Enrollee to a Contract Dentist facility. The Enrollee may request changes to their assigned Contract Dentist facility by contacting Delta Dental's Customer Care at 800-589-4618. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. When searching online for a Contract Dentist, select the DeltaCare USA Network for the list of Contract Dentists applicable to this Plan. The change must be requested prior to the 15th of the month to become effective on the first day of the following month.

2.03 Delta Dental shall pay claims, less any applicable Copayment(s), for all Specialist Services referred by a Contract Dentist and authorized by Delta Dental as described in the attached EOC.

2.04 Upon termination of a Contract Dentist's agreement, Delta Dental shall be liable for Benefits for the completion of treatment for Single Procedures begun prior to the termination of the agreement. The terminating 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).

If, for any reason, the Contract Dentist is unable to complete treatment, Delta Dental shall make reasonable and appropriate provisions for the completion of such treatment by another Contract Dentist.

SECTION 3 - DUTIES OF CONTRACTHOLDER

3.01 **Reporting and Monthly Premiums.** Delta Dental will process eligibility and enrollment as reported by the MPI. Contractholder is responsible for notifying the MPI of additions, changes or terminations made during the prior month. An Enrollee remains enrolled until the Contractholder notifies the MPI of the termination. If the Enrollee loses coverage or makes any change that affects eligibility, Contractholder must promptly notify the MPI of such change.

Delta Dental will not be responsible or liable for any incorrect, incomplete, obsolete or unreadable data or information supplied to Delta Dental including, but not limited to, eligibility and enrollment information.

Delta Dental will not make any payment for services provided to an Enrollee who is not reported to Delta Dental as eligible under this Contract when the service is provided. Also, Delta Dental may not cover Benefits for an Enrollee if Premiums are not paid for the month in which dental services are rendered. Delta Dental shall not be obligated to recover claims paid to a Dentist as a result of Contractholder's retroactive eligibility adjustments. The Contractholder agrees to reimburse Delta Dental for any erroneous claim payments made by Delta Dental as a result of incorrect eligibility reporting by the Contractholder.

3.02 Contractholder will permit Delta Dental to audit Contractholder's records to confirm compliance with Section

3 and the attached EOC. Delta Dental will give Contractholder written notice within a reasonable time before the audit date.

SECTION 4 - RELATIONSHIP OF THE PARTIES

4.01 Independent Contractor. Delta Dental is an independent contractor with Contractholder.

4.02 Indemnification**.** Contractholder shall indemnify, defend and hold harmless Delta Dental, its directors, officers, employees, agents and affiliated companies against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Contractholder's negligent performance or non-performance of its obligations under this Contract.

Delta Dental shall indemnify, defend and hold harmless the Contractholder, its directors, officers, employees, agents and affiliated companies against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Delta Dental's negligent performance or non-performance of its obligations under this Contract.

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

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

4.05 Delta Dental or MPI may refuse, cancel or not renew an Enrollee's enrollment under this Contract if Delta Dental or the MPI demonstrates that the Enrollee committed fraud or an intentional misrepresentation of material fact in obtaining Benefits under this Contract.

An Enrollee and/or Contractholder who believes that coverage has been, or will be, improperly cancelled, rescinded or not renewed may request a review by the Director of the California Department of Managed Health Care in accordance with Section 1365(b) of the California Health and Safety Code.

SECTION 5 - RENEWAL AND TERMINATION

5.01 The initial term of this Contract shall be for the period set forth in the MPI *Group Agreement*.

5.02 Contractholder will receive renewal information from the MPI prior to any applicable Open Enrollment Period. Refer to the MPI *Group Agreement* for further information regarding renewal and termination of the dental plan. Provided Delta Dental continues to make the dental plan available through the MPI at the renewal period, Contractholder may elect to continue to offer coverage under this Contract to Eligible Pediatric Individuals, subject to the applicable Premium available through the MPI for this Contract at the time of renewal.

5.03 In the event of termination for non-payment of Premium, all Benefits shall terminate and Delta Dental shall be released from all further obligations of this Contract, effective on the last day of the month in which written notice of termination is given. Such termination is subject to the grace period described in the MPI *Group Agreement*. Termination for non-payment of Premium will not occur until at least 30 days after the notice of nonpayment is received from the MPI.

5.04 All Benefits shall terminate for any Enrollee as of the date that the MPI *Group Agreement* is terminated, such person ceases to be eligible under the terms of the MPI *Group Agreement*, or such person's enrollment is terminated under the MPI *Group Agreement*. Delta Dental shall not be obligated to continue to provide Benefits to any such person in such event except for completion of Single Procedures commenced while this Contract was in effect.

SECTION 6 - GENERAL PROVISIONS

6.01 Entire Dental Contract; Changes

This Contract, including the EOC and Attachments, is the entire agreement, governing the dental plan between the parties. No agent has authority to change this Contract or waive any of its provisions. No change in this Contract will be valid unless approved by an executive officer of Delta Dental.

6.02 Conformity with Applicable Laws

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

6.03 Not in Lieu of Workers' Compensation

This Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance.

6.04 EOC

Delta Dental will provide the Contractholder with electronic access to an EOC summarizing the Benefits to which Enrollees are entitled. Contractholder will provide each Employee electing coverage under this Contract access to the EOC. Delta Dental will also furnish a hard copy to an Enrollee or the Contractholder upon request. The EOC is not assignable and the Benefits are not assignable prior to a claim. If any amendment to this Contract will materially affect any Benefits described in the EOC, a new EOC or amendment to it showing the change will be issued.

6.05 SDBC

Contractholder will provide each eligible Employee with electronic access to a SDBC supplied by Delta Dental at the following web address: https://www1.deltadentalins.com/group-sites/kaiserpediatrics.html.

6.06 Publications About Plan

Contractholder and Delta Dental agree to consult as is reasonably practical on all material published or distributed about this Contract. No material will be published or distributed which conflicts with the terms of this Contract.

6.07 Notice; Where Directed

All formal notices under this Contract must be in writing and sent by email, facsimile (fax), first-class United States mail, overnight delivery service or personal delivery. Notice by United States mail will be effective 48 hours after mailing with fully pre-paid postage.

Contractholder shall designate in writing a representative for purposes of receiving notices from Delta Dental under this Contract. Contractholder may change its representative at any time with 30 days' written notice to Delta Dental. The Contractholder's representative shall disseminate notices to the Enrollees within 30 days of receipt.

6.08 Incontestability

After this Contract has been in force for three (3) years from the Effective Date, no statement made by the Contractholder will be used to void this Contract. No statement by an Employee or Enrollee with respect to the Enrollee's insurability will be used to reduce or deny a claim or contest the validity of insurance for such Enrollee after that person's coverage has been in effect three (3) years or more during their lifetime.

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

6.09 Compliance with Administrative Simplification, Security and Privacy Regulations

Contractholder and Delta Dental shall comply in all respects with applicable federal, state and local laws and regulations relating to administrative simplification, security and privacy of individually identifiable Enrollee information including executing a Business Associate Addendum as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Contractholder and Delta Dental agree that this Contract shall incorporate terms as necessary and as applicable to execute the required agreements (i.e. business associate agreement) to comply with federal regulations issued under the HIPAA and HITECH Act or to comply with any other enacted administrative simplifications, security or privacy laws or regulations.

6.10 Third Party Administrator ("TPA")

Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under this Contract. Any TPA providing such services or receiving such information shall enter into a separate Business Associate Agreement with Delta Dental, providing that the TPA shall meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

6.11 Mutual Confidentiality

Contractholder and Delta Dental agree to maintain confidential information using the same degree of care (which shall be no less than reasonable care) as each uses to protect its own confidential information of a similar nature and to use confidential information only for specified purposes. Confidential information includes any information which the owner deems confidential, whether marked as confidential or otherwise clearly identifiable as confidential and includes information not generally known by the public or by parties which are competitive with or otherwise in an industry, trade or business similar to the owner of the confidential information. The recipient of confidential information shall notify the owner of any unauthorized disclosure or breach of confidentiality as soon as possible after discovery and without unreasonable delay.

6.12 Trademarks; Service Marks

Unless specifically allowed in this Contract, neither party shall use the name, trademarks, service marks or other proprietary branding of the other party without the advance written approval of the other party.

SECTION 7 - ATTACHMENT

This document is attached to this Contract and made a part of it:

- **EOC** (Form OPGE-CA-dc-23-KFHP)

DeltaCare® USA

DeltaCare USA
Children's Dental HMO

This is a pediatric-only dental benefit

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

Provided by:

Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105

Administered by:

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023
800-589-4618
deltadentalins.com

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

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

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INTRODUCTION

We are pleased to welcome You to the DeltaCare USA Plan ("Plan"). The Contractholder (refer to the "Definitions" section) has selected Delta Dental of California ("Delta Dental") to meet Your dental needs. This Plan is underwritten by Delta Dental and administered by Delta Dental Insurance Company.

IMPORTANT NOTE: This Plan is being offered in conjunction with a medical plan underwritten by Kaiser Foundation Health Plan, Inc. ("Kaiser" or "MPI"). A description of Your medical plan benefits is attached to this EOC. If You have questions regarding Your medical plan coverage, please contact Kaiser at 800-464-4000 (TTY users call 711).

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

Eligibility for coverage under this Plan is determined by Kaiser. Delta Dental provides dental Benefits as defined in the following section of this EOC:

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

Using This EOC

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

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

Request Confidential Communications

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

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

Identification Number – Please provide Your identification ("ID") number to Your assigned Contract Dentist whenever dental services are received. ID cards are not required but may be obtained by visiting Our website at **deltadentalins.com**.

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

Contact Us - For more information, please visit Our website at **deltadentalins.com** or call Our Customer Care at 800-589-4618. A representative can help with: answering questions about Your plan, explaining Benefits, locating a Contract Dentist, language assistance services and filing a grievance. If You prefer to write to us, please mail it to:

DeltaCare USA Customer Care

P.O. Box 1803

Alpharetta, GA 30023

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

DEFINITIONS

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

Accumulation Period: a period of time of at least 12 consecutive months for purposes of accumulating amounts toward Your Out-of-Pocket Maximum. Your Accumulation Period may be a calendar year, a contract year or some other period determined by the Contractholder. Your Accumulation Period is specified in Your MPI *Evidence of Coverage*.

Administrator: Delta Dental Insurance Company or other entity designated by Us, operating as an Administrator in the state of California. Certain functions described throughout this EOC may be performed by the Administrator as designated by Us. The mailing address for the Administrator is: P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-589-4618. Also referred to as a Third Party Administrator or TPA.

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

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

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

Contract Dentist: a DeltaCare USA Dentist who provides services in general dentistry and who has agreed to provide Benefits to Enrollees covered under this Plan.

Contract Orthodontist: a DeltaCare USA Dentist who specializes in orthodontics and who has agreed to provide Benefits to Enrollees covered under this Plan which covers medically necessary orthodontics. Enrollees must obtain a referral from their Contract Dentist to obtain services from a Contract Orthodontist.

Contract Specialist: a DeltaCare USA Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees covered under this Plan. Enrollees must obtain a referral from their Contract Dentist to obtain services from a Contract Specialist.

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

Contractholder: an employer that has contracted for Benefits to Enrollees covered under this Plan.

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

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

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

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

Effective Date: the original date this Packaged Offering starts. This date is given in the MPI *Evidence of Coverage*.

Eligible Pediatric Individual: a person who is eligible to enroll for pediatric dental Benefits as described in this EOC and the MPI *Evidence of Coverage*. Eligible Pediatric Individuals are children from birth through the end of the contract year in which the child turns 19 who meet the eligibility requirements in the MPI *Evidence of Coverage*.

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

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

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

Employee: an individual employed by the Contractholder who has opted to enroll Eligible Pediatric Individuals as described in this EOC and the MPI *Evidence of Coverage*.

Enrollee: an Eligible Pediatric Individual ("Pediatric Enrollee") enrolled to receive Benefits under this Plan.

Enrollee's Effective Date: the date the MPI reports coverage will begin for each Enrollee covered under this Plan.

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

Medical Plan Issuer ("MPI"): entity providing the medical plan that is issued and delivered to the Contractholder with this Plan as a Packaged Offering. For purposes of this EOC, the MPI is Kaiser Foundation Health Plan, Inc.

Open Enrollment Period: the period of the year that the MPI has established when Employees may change coverage selections for the next Contract Term.

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

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

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

Packaged Offering: the combination of a separate medical plan provided by the MPI and this Plan provided by Us.

Pediatric Benefits: Refer to the definition of Essential Health Benefits above.

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

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

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

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

Spouse: a person related to or a domestic partner of the Employee:

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

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

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

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

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

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

ELIGIBILITY AND ENROLLMENT

The MPI is responsible for establishing eligibility and reporting enrollment to Us. The MPI is also responsible for administering any required continuation under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), the Family & Medical Leave Act of 1993, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) and continuation of coverage under the California Continuation Benefits Replacement Act of 1997 (“Cal-COBRA”). We process enrollment as reported by the MPI.

This EOC includes Pediatric Benefits.

Eligibility Requirements for Pediatric Benefits

Enrollees eligible for Pediatric Benefits are:

- an Employee; and/or
- an Employee’s Spouse and dependent children who meet the eligibility requirements as described in the MPI *Evidence of Coverage*.

Enrollment

You may be required to contribute towards the cost of coverage for Pediatric Enrollees. The MPI is responsible for establishing an Enrollee’s Effective Date for enrollment.

Enrollees in the medical plan provided by the MPI are required to enroll under this Plan. Enrollment under this Plan for coverage begins on the date enrollment under the medical plan begins and terminates on the date that enrollment under the medical plan terminates.

Termination of Coverage

Your coverage will be terminated by Us:

- on the date reported by the MPI;
- if the MPI terminates this Packaged Offering; or
- if You are no longer eligible through the MPI.

Please refer to Your MPI *Evidence of Coverage* for further information regarding the renewal and termination of this Plan.

We will not pay for services received after Your coverage ends. However, for Treatment in Progress, We will continue to provide Benefits, less any applicable Copayment(s).

An Enrollee and/or Contractholder who believes that coverage has been, or will be, improperly cancelled, rescinded or not renewed may request a review by the Director of the Department of Managed Health Care (“DMHC”) in accordance with Section 1365(b) of the California Health and Safety Code.

OVERVIEW OF DENTAL BENEFITS

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

What is the DeltaCare USA Plan?

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

Benefits, Limitations and Exclusions

This Plan provides the Benefits described in the Schedules that are a part of this EOC. Except for Emergency Dental Services, Urgent Dental Services and authorized Specialist Services, Benefits are only available in the state of California. Covered dental services are performed as deemed appropriate by Your assigned Contract Dentist.

Copayments and Other Charges

You are required to pay any Copayments listed in Schedule A attached to this EOC. Copayments are paid directly to the Contract Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Contract Dentist at least 24 hours in advance or an Emergency Dental Condition prevented such notice) and charges for visits after normal visiting hours are listed in the Schedules attached to this EOC.

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

We recommend keeping a record of payment for Pediatric Benefits. However, You may request anytime an up-to-date accrual balance toward Your OOPM. If You would like to request this accrual information, please call 800-589-4618. It will be mailed to the address on file unless You elect to receive it electronically.

Non-Covered Services

IMPORTANT: If You opt to receive dental services that are not covered services under this Plan, a Contract Dentist may charge You their usual and customary rate for those services. Prior to providing You with dental services that are not a covered Benefit, the Dentist should provide You with 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 Your dental coverage options, You may call Our Customer Care at 800-589-4618. To fully understand Your coverage, You may wish to carefully review this EOC.

Coordination of Benefits

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

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

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

2) The plan covering the Enrollee as an employee is primary over a plan covering the insured person as a dependent. However, if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is secondary to the plan covering the insured person as a dependent; and primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.

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

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

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

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

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

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

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

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

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

b) Second, the benefits under the continuation coverage.

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

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

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

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

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

We will provide You with Contract Dentists at convenient locations within the Delta Dental Service Area in the state of California during the Contract Term. Upon enrollment, We will assign You to a Contract Dentist facility. You may request changes to Your assigned Contract Dentist facility by calling Our Customer Care at 800-589-4618. A list of Contract Dentists is available to all Enrollees at **deltadentalins.com**. When searching online for a Contract Dentist, select the DeltaCare USA Network to ensure You have the list of Contract Dentists applicable to Your plan. Your change must be requested prior to the 15th of the month to become effective on the first day of the following month.

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

All Treatment in Progress must be completed before You change to another Contract Dentist facility. Examples include: 1) teeth that have been prepared for crowns, 2) root canals where a working length has been established,

3) full or partial dentures for which an impression has been taken and 4) orthodontics when bands have been placed and tooth movement has begun.

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

If Your assigned Contract Dentist facility terminates participation in this Plan, that Contract Dentist facility will complete all Treatment in Progress, as described above. If, for any reason, Your Contract Dentist is unable to complete treatment, We will make reasonable and appropriate provisions for the completion of such treatment by another Contract Dentist.

We will give You reasonable advance written notice if You will be materially or adversely affected by the termination, breach of contract or inability of a Contract Dentist to perform services.

Continuity of Care

If You are a current Enrollee, You may have the right to obtain completion of care under the Contract with Your terminated Contract Dentist for certain specified dental conditions. If You are a new Enrollee, You may have the right to completion of care under the Contract with Your Out-of-Network Dentist for certain specified dental conditions. You must make a specific request for this completion of care Benefit. To make a request, Customer Care at 800-589-4618. You may also contact Us to request a copy of Our *Continuity of Care Policy*. We are not required to continue care with the Dentist if You are not eligible under the Contract or if We cannot reach agreement with the Out-of-Network Dentist or the terminated Contract Dentist on the terms regarding Enrollee care in accordance with California law.

Emergency Dental Services

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

After Emergency Dental Services are received, further non-emergency treatment is usually needed. Non-emergency treatment must be obtained at Your assigned Contract Dentist facility.

You are responsible for any Copayment(s) for Emergency Dental Services received. You are also financially responsible for non-covered services. Non-covered services will not be paid by this Plan.

Urgent Dental Services

<u>Inside the Delta Dental Service Area</u>

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

<u>Outside the Delta Dental Service Area</u>

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

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

You do not need prior Authorization from Us to receive Urgent Dental Services outside the Delta Dental Service Area. Any Urgent Dental Services You received from an Out-of-Network Dentist while outside of the Delta Dental Service

Area are covered by this Plan if the Benefits would have been covered if You had received them from a Contract Dentist.

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

Timely Access to Care

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

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

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

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

Language Assistance Services

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

If You need language interpretation services, materials translated into Your preferred language or into an alternative format, please call Customer Care at 800-589-4618 (TTY: 711). You may also visit the provider directory on Our website which includes self-reported languages by DeltaCare USA Dentists.

Specialist Services

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

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

A Contract Dentist may provide Specialist Services either personally, or through associated Dentists, technicians or hygienists who may lawfully perform the services. If You are 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.

Claims for Reimbursement

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

Dentist Compensation

A Contract Dentist is compensated by Us through monthly capitation (an amount based on the number of Enrollees assigned to the Contract Dentist) and by Enrollees through required Copayments for treatment received. A Contract

Specialist and Contract Orthodontist are compensated by Us through an agreed-upon amount for each covered procedure, less the applicable Copayment(s) paid by You. In no event do We pay a Contract Dentist, a Contract Specialist or a Contract Orthodontist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

You may obtain further information concerning Dentist compensation by calling Us at 800-589-4618.

Processing Policies

The dental care guidelines for this Plan explain to Contract Dentists what services are covered under the dental agreement. Contract Dentists, Contract Specialists and Contract Orthodontists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by a Contract Dentist, Contract Specialist and Contract Orthodontist that fall under the scope of Benefits of this Plan are provided subject to any Copayment(s). If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist will contact Us to determine if the proposed treatment is a covered Benefit and if it requires treatment by a Contract Specialist. You may call Customer Care at 800-589-4618 for information about this Plan's dental care guidelines.

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

Renewal and Termination of Coverage

Please refer to Your MPI *Evidence of Coverage* for further information regarding the renewal and termination of this Plan.

Second Opinion

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

Second opinions will be performed by a licensed Dentist in a timely manner, appropriate to the nature of Your condition. Requests involving an Emergency Dental Condition will be expedited (Authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion Authorizations, call Customer Care at 800-589-4618 or write to Us.

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

Special Health Care Needs

If You believe You have a Special Health Care Need, You should call Customer Care at 800-589-4618. We will confirm whether such a Special Health Care Need exists and what arrangements can be made to assist You in obtaining such Benefits.

We will not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Dentist treating persons with Special Health Care Needs.

Facility Accessibility

Many dental facilities provide Us with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, call Customer Care at 800-589-4618 or visit Our website at **deltadentalins.com**.

ENROLLEE COMPLAINT PROCEDURE

Complaints regarding dental services:

We, or Our Administrator, will notify You if any dental services or claims are denied, in whole or in part, stating the specific reason(s) for the denial. If You have a complaint regarding the denial of dental services or Our claims, policies, procedures or operations or the quality of dental services performed by Your Contract Dentist, You may call Customer Care at **800-589-4618**, complete and submit a **DeltaCare USA Enrollee Grievance Form** online or mail Your grievance to:

Delta Dental of California
Quality Management Department
P.O. Box 997330
Sacramento, CA 95899

Written communication must include: 1) the patient's name, 2) the Pediatric Enrollee's address, telephone number and ID number 3) the Contractholder's name and 4) the Contract Dentist's name and facility location.

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

"Complaint" is the same as "grievance."

"Complainant" is the same as "grievant" and means the person who filed the grievance including the Enrollee, a representative designated by the Enrollee or other individual with authority to act on behalf of the Enrollee.

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

Our grievance system ensures all plan Enrollees have access to and can fully participate in Our grievance process by providing assistance for those with limited-English proficiency or with visual or other communicative impairments. Such assistance includes, but is not limited to, translations of grievance procedures, forms and plan responses to grievances as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. If You are in need of these services and/or have questions about Our grievance process, please call Customer Care at **800-589-4618 (TTY: 711)** and/or visit Our website at **deltadentalins.com** to complete and submit a **DeltaCare USA Enrollee Grievance Form**.

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

You may file a complaint with the DMHC after completing Our grievance process or if You have been involved in Our grievance process for more than 30 days. You may seek assistance or file a grievance immediately with the DMHC in cases involving an imminent and serious threat to Your health including, but not limited to, severe pain, potential loss of life, limb or major bodily function. In such case, We will provide You with a written statement on the disposition or pending status of Your grievance no later than three (3) calendar days from the date of Our receipt of Your grievance. You may file a complaint with the DMHC immediately if You are experiencing an Emergency Dental Condition.

Complaints Involving an Adverse Benefit Determination

If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of this Policy, We will 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. If You believe that the decision was denied on the grounds that it was not medically

necessary, You may contact the DMHC to determine if the decision is eligible for an independent medical review. You will not be discriminated against in any way by Us for filing a grievance.

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

The CA 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 **800-589-4618** and use Your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to You. If You need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Your health plan, or a grievance that has remained unresolved for more than 30 days, You may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If You are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

As the MPI of this Plan, Kaiser is responsible for administering and resolving any Enrollee complaints, grievances and appeals that concern enrollment, premium collection and/or termination relating to this Plan. Please refer to the MPI *Evidence of Coverage* for details.

If the Contractholder is subject to 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 Your 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

GENERAL PROVISIONS

Public Policy Participation by Enrollees

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

Delta Dental of California
Customer Care
P.O. Box 997330
Sacramento, CA 95899-7330

Severability

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

Misstatements on Application; Effect

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

Legal Actions

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

Conformity with Applicable Laws

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

Third Party Administrator ("TPA")

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

Organ and Tissue Donation

Donating organ 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 to Your physician. Organ donation begins at the hospital when a person is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

Non-Discrimination

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

We:

- Provide free aids and services to people with disabilities to communicate effectively with Us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If You need these services, call Customer Care at 800-589-4618 (TTY: 711).

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

Delta Dental
P.O. Box 1803
Alpharetta, GA 30023-1803
Phone: 800-589-4618 (TTY: 711)
Website: **deltadentalins.com**

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019
1-800-537-7697 (TDD)

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

2023 Dental Standard Benefit Plan Design

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs. Children's Dental Plan and Family Dental Plan designs can be offered in both the Individual Marketplace and Covered California for Small Business.		Children’s Dental Plan Copay Plan Pediatric Dental EHB
		Up to Age 19
Actuarial Value		84.33%
		In-Network
Individual Deductible		None
Family Deductible (Two or more children)		Not Applicable
Individual Out of Pocket Maximum		$350
Family Out of Pocket Maximum (Two or More Children)		$700
Office Copay		$0
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d))		None
Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)		None
Procedure Category	Service Type	Member Cost Share
Diagnostic & Preventive	Oral Exam	No charge
	Preventive - Cleaning	No charge
	Preventive - X-ray	No charge
	Sealants per Tooth	No charge
	Topical Fluoride Application	No charge
	Space Maintainers - Fixed	No charge
Basic Services	Restorative Procedures	See 2023 Dental Copay Schedule
	Periodontal Maintenance Services	
Major Services	Periodontics (other than maintenance)	See 2023 Dental Copay Schedule
	Endodontics	
	Crowns and Casts	
	Prosthodontics	
	Oral Surgery	
Orthodontia	Medically Necessary Orthodontia	$350

SCHEDULE A

Description of Benefits and Copayments for Pediatric Enrollees (Under Age 19)

DeltaCare® USA

Children's Dental HMO

For Small Businesses

The Benefits shown below are performed as needed and deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the DeltaCare USA Plan. 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 this Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2022 Procedure Codes, descriptors or nomenclature which is under copyright by the American Dental Association® ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

Pediatric Enrollee………… $350.00 each Contract Year

Multiple Pediatric Enrollees………… $700.00 each Contract Year

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

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

Delta Dental recommends that the Pediatric Enrollee or other party responsible keep a record of payment for Pediatric Benefits. If you have any questions regarding your OOPM, please contact Delta Dental's Customer Care at **800-589-4618**.

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

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D0171	Re-evaluation - post-operative office visit	No charge	
D0180	Comprehensive periodontal evaluation - new or established patient	No charge	*Included with D0150*
D0190	Screening of a patient	Not Covered	
D0191	Assessment of a patient	Not Covered	
D0210	Intraoral - complete series of radiographic images	No charge	*1 series per 36 months per Contract Dentist*
D0220	Intraoral - periapical first radiographic image	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*
D0230	Intraoral - periapical each additional radiographic image	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*
D0240	Intraoral - occlusal radiographic image	No charge	*2 per 6 months per Contract Dentist*
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	No charge	*1 per date of service*
D0251	Extra-oral posterior dental radiographic image	No charge	*4 per date of service*
D0270	Bitewing - single radiographic image	No charge	*1 of (D0270, D0273) per date of service*
D0272	Bitewings - two radiographic images	No charge	*1 of (D0272, D0273) per 6 months per Contract Dentist*
D0273	Bitewings - three radiographic images	No charge	*1 of (D0270, D0273) per date of service;* *1 of (D0272, D0273) per 6 months per Contract Dentist*
D0274	Bitewings - four radiographic images	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*
D0277	Vertical bitewings - 7 to 8 radiographic images	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*
D0310	Sialography	No charge	
D0320	Temporomandibular joint arthrogram, including injection	No charge	*Limited to trauma or pathology; 3 per date of service*
D0322	Tomographic survey	No charge	*2 per 12 months per Contract Dentist*
D0330	Panoramic radiographic image	No charge	*1 per 36 months per Contract Dentist*
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	No charge	*2 per 12 months per Contract Dentist*
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No charge	*For the diagnosis and treatment of the specific clinical condition not apparent on radiographs; 4 per date of service*
D0351	3D photographic image	No charge	*1 per date of service*
D0419	Assessment of salivary flow by measurement	Not Covered	
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Not Covered	
D0460	Pulp vitality tests	No charge	
D0470	Diagnostic casts	No charge	*For the evaluation of orthodontic Benefits only; 1 per Contract Dentist unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment)*
D0502	Other oral pathology procedures, by report	No charge	*Performed by an oral pathologist*
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D0701	Panoramic radiographic image - image capture only	No charge	
D0702	2D cephalometric radiographic image - image capture only	No charge	
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No charge	
D0704	3D photographic image - image capture only	No charge	
D0705	Extra-oral posterior dental radiographic image - image capture only	No charge	
D0706	Intraoral - occlusal radiographic image - image capture only	No charge	
D0707	Intraoral - periapical radiographic image - image capture only	No charge	
D0708	Intraoral - bitewing radiographic image - image capture only	No charge	
D0709	Intraoral - complete series of radiographic images - image capture only	No charge	
D1000-D1999 II. PREVENTIVE			
D1110	Prophylaxis - adult	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1120	Prophylaxis - child	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1206	Topical application of fluoride varnish	No charge	*1 of (D1206, D1208) per 6 months*
D1208	Topical application of fluoride - excluding varnish	No charge	*1 of (D1206, D1208) per 6 months*
D1310	Nutritional counseling for control of dental disease	No charge	
D1320	Tobacco counseling for the control and prevention of oral disease	No charge	
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	No charge	
D1330	Oral hygiene instructions	No charge	
D1351	Sealant - per tooth	No charge	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No charge	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1353	Sealant repair - per tooth	No charge	*The original Contract Dentist or dental office is responsible for any repair or replacement during the 36-month period*
D1354	Interim caries arresting medicament application - per tooth	No charge	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*
D1355	Caries preventive medicament application - per tooth	No charge	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*
D1510	Space maintainer - fixed, unilateral - per quadrant	No charge	*1 per quadrant; posterior teeth*
D1516	Space maintainer - fixed - bilateral, maxillary	No charge	*1 per arch; posterior teeth*
D1517	Space maintainer - fixed - bilateral, mandibular	No charge	*1 per arch; posterior teeth*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D1520	Space maintainer - removable, unilateral - per quadrant	No charge	*1 per quadrant; posterior teeth*
D1526	Space maintainer - removable - bilateral, maxillary	No charge	*1 per arch, through age 17; posterior teeth*
D1527	Space maintainer - removable - bilateral, mandibular	No charge	*1 per arch, through age 17; posterior teeth*
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1556	Removal of fixed unilateral space maintainer - per quadrant	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1557	Removal of fixed bilateral space maintainer - maxillary	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1558	Removal of fixed bilateral space maintainer - mandibular	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	No charge	*1 per quadrant, age 8 and under; posterior teeth*
D2000-D2999 III. RESTORATIVE			
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.			
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years (60+ months) old.			
D2140	Amalgam - one surface, primary or permanent	$25	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2150	Amalgam - two surfaces, primary or permanent	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2160	Amalgam - three surfaces, primary or permanent	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2161	Amalgam - four or more surfaces, primary or permanent	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2330	Resin-based composite - one surface, anterior	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2331	Resin-based composite - two surfaces, anterior	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2332	Resin-based composite - three surfaces, anterior	$55	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$60	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2390	Resin-based composite crown, anterior	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2391	Resin-based composite - one surface, posterior	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D2392	Resin-based composite - two surfaces, posterior	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2393	Resin-based composite - three surfaces, posterior	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2394	Resin-based composite - four or more surfaces, posterior	$70	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2542	Onlay - metallic - two surfaces	Not Covered	
D2543	Onlay - metallic - three surfaces	Not Covered	
D2544	Onlay - metallic - four or more surfaces	Not Covered	
D2642	Onlay - porcelain/ceramic - two surfaces	Not Covered	
D2643	Onlay - porcelain/ceramic - three surfaces	Not Covered	
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not Covered	
D2662	Onlay - resin-based composite - two surfaces	Not Covered	
D2663	Onlay - resin-based composite - three surfaces	Not Covered	
D2664	Onlay - resin-based composite - four or more surfaces	Not Covered	
D2710	Crown - resin-based composite (indirect)	$140	*1 per 60 months, permanent teeth; age 13 through 18*
D2712	Crown - 3/4 resin-based composite (indirect)	$190	*1 per 60 months, permanent teeth; age 13 through 18*
D2720	Crown - resin with high noble metal	Not Covered	
D2721	Crown - resin with predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2722	Crown - resin with noble metal	Not Covered	
D2740	Crown - porcelain/ceramic substrate	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2750	Crown - porcelain fused to high noble metal	Not Covered	
D2751	Crown - porcelain fused to predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2752	Crown - porcelain fused to noble metal	Not Covered	
D2753	Crown - porcelain fused to titanium and titanium alloys	Not Covered	
D2780	Crown - 3/4 cast high noble metal	Not Covered	
D2781	Crown - 3/4 cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2782	Crown - 3/4 cast noble metal	Not Covered	
D2783	Crown - 3/4 porcelain/ceramic	$310	*1 per 60 months, permanent teeth; age 13 through 18*
D2790	Crown - full cast high noble metal	Not Covered	
D2791	Crown - full cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2792	Crown - full cast noble metal	Not Covered	
D2794	Crown - titanium and titanium alloys	Not Covered	
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$25	*1 per 12 months per Contract Dentist*
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$25	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D2920	Re-cement or re-bond crown	$25	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45	*1 per 12 months*
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$120	*1 per 36 months*
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95	*1 per 12 months*
D2930	Prefabricated stainless steel crown - primary tooth	$65	*1 per 12 months*
D2931	Prefabricated stainless steel crown - permanent tooth	$75	*1 per 36 months*
D2932	Prefabricated resin crown	$75	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2933	Prefabricated stainless steel crown with resin window	$80	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2940	Protective restoration	$25	*1 per 6 months per Contract Dentist*
D2941	Interim therapeutic restoration - primary dentition	$30	*1 per tooth per 6 months per Contract Dentist*
D2949	Restorative foundation for an indirect restoration	$45	
D2950	Core buildup, including any pins when required	$20	
D2951	Pin retention - per tooth, in addition to restoration	$25	*1 per tooth regardless of the number of pins placed; permanent teeth*
D2952	Post and core in addition to crown, indirectly fabricated	$100	*Base metal post; 1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2953	Each additional indirectly fabricated post - same tooth	$30	*Performed in conjunction with D2952*
D2954	Prefabricated post and core in addition to crown	$90	*1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2955	Post removal	$60	*Included in case fee by Contract Dentist or dental office who performed endodontic and restorative procedures. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2957	Each additional prefabricated post - same tooth	$35	*Performed in conjunction with D2954*
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	$35	*Included in the fee for laboratory processed crowns. The listed fee applies for service provided by a Contract Dentist other than the original treating Dentist/dental office.*
D2980	Crown repair necessitated by restorative material failure	$50	*Repair during the 12 months following initial placement or previous repair is included, no additional charge to the Enrollee or plan is permitted by the original treating Contract Dentist/dental office.*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D2999	Unspecified restorative procedure, by report	$40	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D3000-D3999 IV. ENDODONTICS			
D3110	Pulp cap - direct (excluding final restoration)	$20	
D3120	Pulp cap - indirect (excluding final restoration)	$25	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$40	*1 per primary tooth*
D3221	Pulpal debridement, primary and permanent teeth	$40	*1 per tooth*
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60	*1 per permanent tooth*
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$55	*1 per tooth*
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$55	*1 per tooth*
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$195	*Root canal*
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$235	*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$300	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$50	
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Not Covered	
D3333	Internal root repair of perforation defects	$80	
D3346	Retreatment of previous root canal therapy - anterior	$240	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3347	Retreatment of previous root canal therapy - bicuspid	$295	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3348	Retreatment of previous root canal therapy - molar	$365	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$85	*1 per permanent tooth*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D3352	Apexification/recalcification - interim medication replacement	$45	*1 per permanent tooth*
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	Not Covered	
D3410	Apicoectomy - anterior	$240	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3421	Apicoectomy - bicuspid (first root)	$250	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3425	Apicoectomy - molar (first root)	$275	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3426	Apicoectomy (each additional root)	$110	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only; a Benefit for 3rd molar if it occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.*
D3430	Retrograde filling - per root	$90	
D3450	Root amputation - per root	Not Covered	
D3471	Surgical repair of root resorption - anterior	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3472	Surgical repair of root resorption - premolar	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3473	Surgical repair of root resorption - molar	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	
D3920	Hemisection (including any root removal), not including root canal therapy	Not Covered	
D3950	Canal preparation and fitting of preformed dowel or post	Not Covered	
D3999	Unspecified endodontic procedure, by report	$100	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D4000-D4999 V. PERIODONTICS			
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$150	*1 per quadrant per 36 months, age 13+*
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50	*1 per quadrant per 36 months, age 13+*
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Not Covered	
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	Not Covered	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D4249	Clinical crown lengthening - hard tissue	$165	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$265	*1 per quadrant per 36 months, age 13+*
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$140	*1 per quadrant per 36 months, age 13+*
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	Not Covered	
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	Not Covered	
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	$80	
D4266	Guided tissue regeneration - resorbable barrier, per site	Not Covered	
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	Not Covered	
D4270	Pedicle soft tissue graft procedure	Not Covered	
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	Not Covered	
D4275	Non-autogenous connective tissue graft procedure (including recipient site and donor material) – first tooth, implant or edentulous tooth position in same graft site	Not Covered	
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered	
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$55	*1 per quadrant per 24 months; age 13+*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30	*1 per quadrant per 24 months; age 13+*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$40	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$40	*1 treatment per 12 consecutive months*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10	
D4910	Periodontal maintenance	$30	*1 per 3 months; service must be within the 24 months following the last scaling and root planing*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$15	*1 per Contract Dentist; age 13+*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D4999	Unspecified periodontal procedure, by report	$350	*Enrollees age 13+. Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5000-D5899 VI. PROSTHODONTICS (removable)			
- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.			
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.			
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years (60+ months) old.			
D5110	Complete denture - maxillary	$300	*1 per 60 months*
D5120	Complete denture - mandibular	$300	*1 per 60 months*
D5130	Immediate denture - maxillary	$300	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*
D5140	Immediate denture - mandibular	$300	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$300	*1 per 60 months*
D5212	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$300	*1 per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$335	*1 per 60 months*
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$335	*1 per 60 months*
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$275	*1 per 60 months*
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$275	*1 per 60 months*
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330	*1 per 60 months*
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330	*1 per 60 months*
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests and teeth)	Not Covered	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests and teeth)	Not Covered	
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	Not Covered	
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	Not Covered	
D5284	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests and teeth), per quadrant	Not Covered	
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests and teeth), per quadrant	Not Covered	
D5410	Adjust complete denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5411	Adjust complete denture - mandibular	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5421	Adjust partial denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5422	Adjust partial denture - mandibular	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5511	Repair broken complete denture base, mandibular	$40	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5512	Repair broken complete denture base, maxillary	$40	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5520	Replace missing or broken teeth - complete denture (each tooth)	$40	*Up to 4 per arch per date of service after the initial 6 months; up to 2 per arch per 12 months per Contract Dentist*
D5611	Repair resin partial denture base, mandibular	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5612	Repair resin partial denture base, maxillary	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5621	Repair cast partial framework, mandibular	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5622	Repair cast partial framework, maxillary	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5630	Repair or replace broken retentive clasping materials - per tooth	$50	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5640	Replace broken teeth - per tooth	$35	*4 per arch per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5650	Add tooth to existing partial denture	$35	*Up to 3 per date of service per Contract Dentist; 1 per tooth after the initial 6 months*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D5660	Add clasp to existing partial denture - per tooth	$60	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not Covered	
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not Covered	
D5710	Rebase complete maxillary denture	Not Covered	
D5711	Rebase complete mandibular denture	Not Covered	
D5720	Rebase maxillary partial denture	Not Covered	
D5721	Rebase mandibular partial denture	Not Covered	
D5730	Reline complete maxillary denture (direct)	$60	*Included for the first 6 months after placement by the Contract Dentist or dental office where the appliance was originally delivered; 1 per 12 month period after the initial 6 months*
D5731	Reline complete mandibular denture (direct)	$60	*1 per 12 month period after the initial 6 months*
D5740	Reline maxillary partial denture (direct)	$60	*1 per 12 month period after the initial 6 months*
D5741	Reline mandibular partial denture (direct)	$60	*1 per 12 month period after the initial 6 months*
D5750	Reline complete maxillary denture (indirect)	$90	*1 per 12 month period after the initial 6 months*
D5751	Reline complete mandibular denture (indirect)	$90	*1 per 12 month period after the initial 6 months*
D5760	Reline maxillary partial denture (indirect)	$80	*1 per 12 month period after the initial 6 months*
D5761	Reline mandibular partial denture (indirect)	$80	*1 per 12 month period after the initial 6 months*
D5850	Tissue conditioning, maxillary	$30	*2 per prosthesis per 36 months after the initial 6 months*
D5851	Tissue conditioning, mandibular	$30	*2 per prosthesis per 36 months after the initial 6 months*
D5862	Precision attachment, by report	$90	*Included in the fee for prosthetic and restorative procedures by the Contract Dentist or dental office where the service was originally delivered. The listed fee applies for service provided by a dentist other than the original treating Contract Dentist or dental office.*
D5863	Overdenture - complete maxillary	$300	*1 per 60 months*
D5864	Overdenture - partial maxillary	$300	*1 per 60 months*
D5865	Overdenture - complete mandibular	$300	*1 per 60 months*
D5866	Overdenture - partial mandibular	$300	*1 per 60 months*
D5876	Add metal substructure to acrylic full denture (per arch)	Not Covered	
D5899	Unspecified removable prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS			
- All maxillofacial prosthetic procedures require prior Authorization.			
D5911	Facial moulage (sectional)	$285	
D5912	Facial moulage (complete)	$350	
D5913	Nasal prosthesis	$350	
D5914	Auricular prosthesis	$350	
D5915	Orbital prosthesis	$350	
D5916	Ocular prosthesis	$350	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D5919	Facial prosthesis	$350	
D5922	Nasal septal prosthesis	$350	
D5923	Ocular prosthesis, interim	$350	
D5924	Cranial prosthesis	$350	
D5925	Facial augmentation implant prosthesis	$200	
D5926	Nasal prosthesis, replacement	$200	
D5927	Auricular prosthesis, replacement	$200	
D5928	Orbital prosthesis, replacement	$200	
D5929	Facial prosthesis, replacement	$200	
D5931	Obturator prosthesis, surgical	$350	
D5932	Obturator prosthesis, definitive	$350	
D5933	Obturator prosthesis, modification	$150	*2 per 12 months*
D5934	Mandibular resection prosthesis with guide flange	$350	
D5935	Mandibular resection prosthesis without guide flange	$350	
D5936	Obturator prosthesis, interim	$350	
D5937	Trismus appliance (not for TMD treatment)	$85	
D5951	Feeding aid	$135	
D5952	Speech aid prosthesis, pediatric	$350	
D5953	Speech aid prosthesis, adult	$350	
D5954	Palatal augmentation prosthesis	$135	
D5955	Palatal lift prosthesis, definitive	$350	
D5958	Palatal lift prosthesis, interim	$350	
D5959	Palatal lift prosthesis, modification	$145	*2 per 12 months*
D5960	Speech aid prosthesis, modification	$145	*2 per 12 months*
D5982	Surgical stent	$70	
D5983	Radiation carrier	$55	
D5984	Radiation shield	$85	
D5985	Radiation cone locator	$135	
D5986	Fluoride gel carrier	$35	
D5987	Commissure splint	$85	
D5988	Surgical splint	$95	
D5991	Vesiculobullous disease medicament carrier	$70	
D5999	Unspecified maxillofacial prosthesis, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D6000-D6199 VIII. IMPLANT SERVICES			
- A Benefit only under exceptional medical conditions. Prior Authorization is required. Refer also to Schedule B.			
D6010	Surgical placement of implant body: endosteal implant	$350	*A Benefit only under exceptional medical conditions*
D6011	Surgical access to an implant body (second stage implant surgery)	$350	*A Benefit only under exceptional medical conditions*
D6013	Surgical placement of mini implant	$350	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D6040	Surgical placement: eposteal implant	$350	*A Benefit only under exceptional medical conditions*
D6050	Surgical placement: transosteal implant	$350	*A Benefit only under exceptional medical conditions*
D6055	Connecting bar - implant supported or abutment supported	$350	*A Benefit only under exceptional medical conditions*
D6056	Prefabricated abutment - includes modification and placement	$135	*A Benefit only under exceptional medical conditions*
D6057	Custom fabricated abutment - includes placement	$180	*A Benefit only under exceptional medical conditions*
D6058	Abutment supported porcelain/ceramic crown	$320	*A Benefit only under exceptional medical conditions*
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295	*A Benefit only under exceptional medical conditions*
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300	*A Benefit only under exceptional medical conditions*
D6062	Abutment supported cast metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6063	Abutment supported cast metal crown (predominantly base metal)	$300	*A Benefit only under exceptional medical conditions*
D6064	Abutment supported cast metal crown (noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6065	Implant supported porcelain/ceramic crown	$340	*A Benefit only under exceptional medical conditions*
D6066	Implant supported crown - porcelain fused to high noble alloys	$335	*A Benefit only under exceptional medical conditions*
D6067	Implant supported crown - high noble alloys	$340	*A Benefit only under exceptional medical conditions*
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320	*A Benefit only under exceptional medical conditions*
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions*
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300	*A Benefit only under exceptional medical conditions*
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions*
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320	*A Benefit only under exceptional medical conditions*
D6075	Implant supported retainer for ceramic FPD	$335	*A Benefit only under exceptional medical conditions*
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$330	*A Benefit only under exceptional medical conditions*
D6077	Implant supported retainer for metal FPD - high noble alloys	$350	*A Benefit only under exceptional medical conditions*
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$30	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$30	*A Benefit only under exceptional medical conditions*
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$335	*A Benefit only under exceptional medical conditions.*
D6083	Implant supported crown - porcelain fused to noble alloys	$335	*A Benefit only under exceptional medical conditions*
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$335	*A Benefit only under exceptional medical conditions*
D6085	Provisional implant crown	$300	*A Benefit only under exceptional medical conditions*
D6086	Implant supported crown - predominantly base alloys	$340	*A Benefit only under exceptional medical conditions*
D6087	Implant supported crown - noble alloys	$340	*A Benefit only under exceptional medical conditions*
D6088	Implant supported crown - titanium and titanium alloys	$340	*A Benefit only under exceptional medical conditions*
D6090	Repair implant supported prosthesis, by report	$65	*A Benefit only under exceptional medical conditions*
D6091	Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40	*A Benefit only under exceptional medical conditions*
D6092	Re-cement or re-bond implant/abutment supported crown	$25	*A Benefit only under exceptional medical conditions*
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$35	*A Benefit only under exceptional medical conditions*
D6094	Abutment supported crown - titanium and titanium alloys	$295	*A Benefit only under exceptional medical conditions*
D6095	Repair implant abutment, by report	$65	*A Benefit only under exceptional medical conditions*
D6096	Remove broken implant retaining screw	$60	*A Benefit only under exceptional medical conditions*
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$315	*A Benefit only under exceptional medical conditions*
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330	*A Benefit only under exceptional medical conditions*
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$330	*A Benefit only under exceptional medical conditions*
D6100	Surgical removal of implant body	$110	*A Benefit only under exceptional medical conditions*
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	$350	*A Benefit only under exceptional medical conditions*
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary	$350	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular	$350	*A Benefit only under exceptional medical conditions*
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	$350	*A Benefit only under exceptional medical conditions*
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	$350	*A Benefit only under exceptional medical conditions*
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$330	*A Benefit only under exceptional medical conditions*
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350	*A Benefit only under exceptional medical conditions*
D6122	Implant supported retainer for metal FPD - noble alloys	$350	*A Benefit only under exceptional medical conditions*
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350	*A Benefit only under exceptional medical conditions*
D6190	Radiographic/surgical implant index, by report	$75	*A Benefit only under exceptional medical conditions*
D6191	Semi-precision abutment - placement	$350	*A Benefit only under exceptional medical conditions*
D6192	Semi-precision attachment – placement	$350	*A Benefit only under exceptional medical conditions*
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	$265	*A Benefit only under exceptional medical conditions*
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315	*A Benefit only under exceptional medical conditions*
D6199	Unspecified implant procedure, by report	$350	*Implant services are a Benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Written documentation shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.*
D6200-D6999 IX. PROSTHODONTICS, fixed			
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge).			
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years (60+ months) old.			
D6205	Pontic - indirect resin based composite	Not Covered	
D6210	Pontic - cast high noble metal	Not Covered	
D6211	Pontic - cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6212	Pontic - cast noble metal	Not Covered	
D6214	Pontic - titanium and titanium alloys	Not Covered	
D6240	Pontic - porcelain fused to high noble metal	Not Covered	
D6241	Pontic - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6242	Pontic - porcelain fused to noble metal	Not Covered	
D6243	Pontic - porcelain fused to titanium and titanium alloys	Not Covered	
D6245	Pontic - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6250	Pontic - resin with high noble metal	Not Covered	
D6251	Pontic - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6252	Pontic - resin with noble metal	Not Covered	
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Not Covered	
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Not Covered	
D6549	Retainer – for resin bonded fixed prosthesis	Not Covered	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D6608	Retainer onlay - porcelain/ceramic, two surfaces	Not Covered	
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	Not Covered	
D6610	Retainer onlay - cast high noble metal, two surfaces	Not Covered	
D6611	Retainer onlay - cast high noble metal, three or more surfaces	Not Covered	
D6612	Retainer onlay - cast predominantly base metal, two surfaces	Not Covered	
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	Not Covered	
D6614	Retainer onlay - cast noble metal, two surfaces	Not Covered	
D6615	Retainer onlay - cast noble metal, three or more surfaces	Not Covered	
D6634	Retainer onlay - titanium	Not Covered	
D6710	Retainer crown - indirect resin based composite	Not Covered	
D6720	Retainer crown - resin with high noble metal	Not Covered	
D6721	Retainer crown - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6722	Retainer crown - resin with noble metal	Not Covered	
D6740	Retainer crown - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6750	Retainer crown - porcelain fused to high noble metal	Not Covered	
D6751	Retainer crown - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6752	Retainer crown - porcelain fused to noble metal	Not Covered	
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	Not Covered	
D6781	Retainer crown - 3/4 cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6782	Retainer crown - 3/4 cast noble metal	Not Covered	
D6783	Retainer crown - 3/4 porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6784	Retainer crown - 3/4 titanium and titanium alloys	$300	*1 per 60 months; age 13+*
D6791	Retainer crown - full cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6794	Retainer crown - titanium and titanium alloys	Not Covered	
D6930	Re-cement or re-bond fixed partial denture	$40	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D6980	Fixed partial denture repair necessitated by restorative material failure	$95	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D6999	Unspecified fixed prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment. Not a Benefit within 12 months of initial placement of a fixed partial denture by the same Contract Dentist/office.*
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY			
- Prior Authorization required for procedures performed by a Contract Specialist. Medical necessity must be demonstrated for procedures D7340 - D7997. Refer also to Schedule B.			
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic. Post-operative services include exams, suture removal and treatment of complications.			
D7111	Extraction, coronal remnants - deciduous tooth	$40	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$120	
D7220	Removal of impacted tooth - soft tissue	$95	
D7230	Removal of impacted tooth - partially bony	$145	
D7240	Removal of impacted tooth - completely bony	$160	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175	
D7250	Removal of residual tooth roots (cutting procedure)	$80	
D7260	Oroantral fistula closure	$280	
D7261	Primary closure of a sinus perforation	$285	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$185	*1 per arch regardless of number of teeth involved; permanent anterior teeth*
D7280	Exposure of an unerupted tooth	$220	
D7283	Placement of device to facilitate eruption of impacted tooth	$85	*For active orthodontic treatment only*
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$180	*1 per arch per date of service; regardless of number of areas involved*
D7286	Incisional biopsy of oral tissue-soft	$110	*3 per date of service*
D7287	Exfoliative cytological sample collection	Not Covered	
D7288	Brush biopsy - transepithelial sample collection	Not Covered	
D7290	Surgical repositioning of teeth	$185	*1 per arch, for permanent teeth only; applies to active orthodontic treatment*
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	*1 per arch; applies to active orthodontic treatment*
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$85	
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$120	
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65	
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$350	*1 per arch per 60 months*
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350	*1 per arch*
D7410	Excision of benign lesion up to 1.25 cm	$75	
D7411	Excision of benign lesion greater than 1.25 cm	$115	
D7412	Excision of benign lesion, complicated	$175	
D7413	Excision of malignant lesion up to 1.25 cm	$95	
D7414	Excision of malignant lesion greater than 1.25 cm	$120	
D7415	Excision of malignant lesion, complicated	$255	
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$105	
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$185	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180	
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330	
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155	
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250	
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	
D7471	Removal of lateral exostosis (maxilla or mandible)	$140	*1 per quadrant*
D7472	Removal of torus palatinus	$145	*1 per lifetime*
D7473	Removal of torus mandibularis	$140	*1 per quadrant*
D7485	Reduction of osseous tuberosity	$105	*1 per quadrant*
D7490	Radical resection of maxilla or mandible	$350	
D7510	Incision and drainage of abscess - intraoral soft tissue	$70	*1 per quadrant per date of service*
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$70	*1 per quadrant per date of service*
D7520	Incision and drainage of abscess - extraoral soft tissue	$70	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80	
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45	*1 per date of service*
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	*1 per date of service*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	*1 per quadrant per date of service*
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	
D7610	Maxilla - open reduction (teeth immobilized, if present)	$140	
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$250	
D7630	Mandible - open reduction (teeth immobilized, if present)	$350	
D7640	Mandible - closed reduction (teeth immobilized, if present)	$350	
D7650	Malar and/or zygomatic arch - open reduction	$350	
D7660	Malar and/or zygomatic arch - closed reduction	$350	
D7670	Alveolus - closed reduction, may include stabilization of teeth	$170	
D7671	Alveolus - open reduction, may include stabilization of teeth	$230	
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350	
D7710	Maxilla - open reduction	$110	
D7720	Maxilla - closed reduction	$180	
D7730	Mandible - open reduction	$350	
D7740	Mandible - closed reduction	$290	
D7750	Malar and/or zygomatic arch - open reduction	$220	
D7760	Malar and/or zygomatic arch - closed reduction	$350	
D7770	Alveolus - open reduction stabilization of teeth	$135	
D7771	Alveolus, closed reduction stabilization of teeth	$160	
D7780	Facial bones - complicated reduction with fixation and multiple approaches	$350	
D7810	Open reduction of dislocation	$350	
D7820	Closed reduction of dislocation	$80	
D7830	Manipulation under anesthesia	$85	
D7840	Condylectomy	$350	
D7850	Surgical discectomy, with/without implant	$350	
D7852	Disc repair	$350	
D7854	Synovectomy	$350	
D7856	Myotomy	$350	
D7858	Joint reconstruction	$350	
D7860	Arthrotomy	$350	
D7865	Arthroplasty	$350	
D7870	Arthrocentesis	$90	
D7871	Non-arthroscopic lysis and lavage	$150	
D7872	Arthroscopy - diagnosis, with or without biopsy	$350	
D7873	Arthroscopy: lavage and lysis of adhesions	$350	
D7874	Arthroscopy: disc repositioning and stabilization	$350	
D7875	Arthroscopy: synovectomy	$350	
D7876	Arthroscopy: discectomy	$350	
D7877	Arthroscopy: debridement	$350	
D7880	Occlusal orthotic device, by report	$120	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D7881	Occlusal orthotic device adjustment	$30	*1 per date of service per Contract Dentist; 2 per 12 months per Contract Dentist*
D7899	Unspecified TMD therapy, by report	$350	
D7910	Suture of recent small wounds up to 5 cm	$35	
D7911	Complicated suture - up to 5 cm	$55	
D7912	Complicated suture - greater than 5 cm	$130	
D7920	Skin graft (identify defect covered, location and type of graft)	$120	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80	
D7940	Osteoplasty - for orthognathic deformities	$160	
D7941	Osteotomy - mandibular rami	$350	
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350	
D7944	Osteotomy - segmented or subapical	$275	
D7945	Osteotomy - body of mandible	$350	
D7946	LeFort I (maxilla - total)	$350	
D7947	LeFort I (maxilla - segmented)	$350	
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350	
D7949	LeFort II or LeFort III - with bone graft	$350	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	$190	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	
D7952	Sinus augmentation via a vertical approach	$175	
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	
D7961	Buccal/labial frenectomy (frenulectomy)	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7962	Lingual frenectomy (frenulectomy)	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7963	Frenuloplasty	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7970	Excision of hyperplastic tissue - per arch	$175	*1 per arch per date of service*
D7971	Excision of pericoronal gingiva	$80	
D7972	Surgical reduction of fibrous tuberosity	$100	*1 per quadrant per date of service*
D7979	Non-surgical sialolithotomy	$155	
D7980	Sialolithotomy	$155	
D7981	Excision of salivary gland, by report	$120	
D7982	Sialodochoplasty	$215	
D7983	Closure of salivary fistula	$140	
D7990	Emergency tracheotomy	$350	
D7991	Coronoidectomy	$345	
D7995	Synthetic graft - mandible or facial bones, by report	$150	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	*Removal of appliances related to surgical procedures only; 1 per arch per date of service; the listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D7999	Unspecified oral surgery procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees ONLY			
- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.			
- Pediatric Enrollee must continue to be eligible, Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.			
- Comprehensive orthodontic treatment procedure (D8080) includes all appliances, adjustments, insertion, removal and post treatment stabilization (retention). The Enrollee must continue to be eligible during active treatment. No additional charge to the Enrollee is permitted from the original treating Contract Orthodontist or dental office who received the comprehensive case fee. A separate fee applies for services provided by a Contract Orthodontist other than the original treating Contract Orthodontist or dental office.			
- Copayment for medically necessary orthodontics applies to course of treatment, not individual benefit years within a multi-year course of treatment. This Copayment applies to the course of treatment as long as the Pediatric Enrollee remains enrolled in this Plan.			
- Refer to Schedule B for additional information on medically necessary orthodontics.			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350	*1 per Enrollee per phase of treatment*
D8210	Removable appliance therapy		*1 per lifetime; age 6 through 12*
D8220	Fixed appliance therapy		*1 per lifetime; age 6 through 12*
D8660	Pre-orthodontic treatment examination to monitor growth and development		*1 per 3 months when performed by the same Contract Dentist or dental office; up to 6 visits per lifetime*
D8670	Periodic orthodontic treatment visit		*Included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		*1 per arch for each authorized phase of orthodontic treatment; included in comprehensive case fee*
D8681	Removable orthodontic retainer adjustment		
D8696	Repair of orthodontic appliance – maxillary		*1 per appliance; included in comprehensive case fee*
D8697	Repair of orthodontic appliance – mandibular		*1 per appliance; included in comprehensive case fee*
D8698	Re-cement or re-bond fixed retainer – maxillary		*1 per Contract Dentist; included in comprehensive case fee*
D8699	Re-cement or re-bond fixed retainer – mandibular		*1 per Contract Dentist; included in comprehensive case fee*
D8701	Repair of fixed retainer, includes reattachment - maxillary		*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D8702	Repair of fixed retainer, includes reattachment - mandibular		*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*
D8703	Replacement of lost or broken retainer – maxillary		*1 per arch; within 24 months following the date of service for orthodontic retention (D8680); included in comprehensive case fee*
D8704	Replacement of lost or broken retainer – mandibular		*1 per arch; within 24 months following the date of service for orthodontic retention (D8680); included in comprehensive case fee*
D8999	Unspecified orthodontic procedure, by report		*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES			
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$30	*1 per date of service per Contract Dentist; regardless of the number of teeth and/or areas treated*
D9120	Fixed partial denture sectioning	$95	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$10	*1 per date of service per Contract Dentist; for use to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state*
D9211	Regional block anesthesia	$20	
D9212	Trigeminal division block anesthesia	$60	
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	
D9222	Deep sedation/general anesthesia - first 15 minutes	$45	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$45	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15	*(Where available)*
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$60	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$60	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9248	Non-intravenous conscious sedation	$65	*Where available; 1 per date of service per Contract Dentist*
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50	
D9311	Consultation with a medical health professional	No charge	
D9410	House/extended care facility call	$50	*1 per Enrollee per date of service*
D9420	Hospital or ambulatory surgical center call	$135	
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$20	*1 per date of service per Contract Dentist*

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D9440	Office visit - after regularly scheduled hours	$45	*1 per date of service per Contract Dentist*
D9450	Case presentation, detailed and extensive treatment planning	Not Covered	
D9610	Therapeutic parenteral drug, single administration	$30	*4 of (D9610, D9612) injections per date of service*
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$40	*4 of (D9610, D9612) injections per date of service*
D9910	Application of desensitizing medicament	$20	*1 per 12 months per Contract Dentist; permanent teeth*
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$35	*1 per date of service per Contract Dentist within 30 days of an extraction*
D9942	Repair and/or reline of occlusal guard	Not Covered	
D9943	Occlusal guard adjustment	Not Covered	
D9944	Occlusal guard – hard appliance, full arch	Not Covered	
D9945	Occlusal guard – soft appliance, full arch	Not Covered	
D9946	Occlusal guard – hard appliance, partial arch	Not Covered	
D9950	Occlusion analysis - mounted case	$120	*Prior Authorization is required; 1 per 12 months for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9951	Occlusal adjustment - limited	$45	*1 per 12 months for quadrant per Contract Dentist; age 13+*
D9952	Occlusal adjustment - complete	$210	*1 per 12 months following occlusion analysis - mounted case (D9950) for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9995	Teledentistry - synchronous; real-time encounter	Not Covered	
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	Not Covered	
D9997	Dental case management - patients with Special Health Care Needs	No charge	
D9999	Unspecified adjunctive procedure, by report	No charge	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

Endnotes:

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment(s). Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Copayment(s) specified for such services.

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

Example of an Optional or upgraded procedure:

- If the Enrollee chooses an Optional or upgraded procedure presented by the Contract Dentist,

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

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

Additional Endnotes to Covered California’s 2023 Dental Standard Benefit Plan Designs

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

1. In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.
2. In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum.
3. Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (“EPSDT”) Benefit.

SCHEDULE B
Limitations and Exclusions of Benefits for Pediatric Enrollees (Under age 19)
DeltaCare® USA
Children's Dental HMO
For Small Businesses

Limitations of Benefits for Pediatric Enrollees

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments for Pediatric Enrollees* ("Schedule A"). Additional requests, beyond the stated frequency limitations, for prophylaxis, fluoride and scaling procedures (D1110, D1120, D1206, D1208 and D4346) shall be considered for prior Authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.

2. A filling [D2140-D2161, D2330-D2335, D2391-D2394] is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.

3. A crown [D2390 and covered codes only between D2710-D2791] is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five+ year (60+ months) limitation.

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

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

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

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

6. Immediate dentures [D5130, D5140, D5221–D5224] are covered when one or more of the following conditions are present:

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

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

8. All maxillofacial prosthetic procedures [covered codes only between D5911-D5999] require prior authorization for medically necessary procedures.

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

   a. Cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prosthesis.
   b. Severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures [D7340, D7350] or osseous augmentation procedures [D7950], and the Enrollee is unable to function with conventional prosthesis.
   c. Skeletal deformities that preclude the use of conventional prosthesis (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).

10. Temporomandibular joint dysfunction ("TMJ") procedure codes [covered codes only between D7810-D7880] are limited to differential diagnosis and symptomatic care and require prior Authorization.

11. Certain listed procedures performed by a Contract Specialist may be considered to be primary under the Enrollee's medical coverage. Dental Benefits will be coordinated accordingly.

12. Deep sedation/general anesthesia [D9222, D9223] or intravenous conscious sedation/analgesia [D9239, D9243] for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.

Exclusions of Benefits for Pediatric Enrollees

1. Any procedure that is not specifically listed under *Schedule A*, except as required by state or federal law.

2. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

3. Lost or theft of full or partial dentures [covered codes only between D5110-D5140, D5211-D5214, D5221-D5224], space maintainers [D1510–D1575], crowns [D2390 and covered codes only between D2710–D2791], fixed partial dentures (bridges) [covered codes only between D6211-D6245, D6251, D6721-D6791] or other appliances.

4. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.

5. Dental expenses incurred in connection with any dental procedure before the Enrollee's eligibility in this Plan. Examples include: teeth prepared for crowns, partials and dentures, root canals in progress.

6. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.) unless included in *Schedule A*.

7. Dispensing of drugs not normally supplied in a dental facility unless included in *Schedule A*.

8. Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:

   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
   b. is inconsistent with generally accepted standards for dentistry.

9. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized or as cited under the "Emergency Dental Services" and "Urgent Dental Services" sections of the EOC. To obtain written Authorization, the Enrollee should call Delta Dental's Customer Care at 800-589-4618.

10. Consultations [D9310, D9311] or other diagnostic services [covered codes only between D0120–D0999], for non-covered Benefits.

11. Single tooth implants [covered codes only between D6000–D6199].

12. Restorations [covered codes only between D2330-D2335, D2391-D2394, D2710-D2791, D6211-D6245, D6251, D6721-D6791] placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

13. Preventive [covered codes only between D1110-D1575], endodontic [covered codes only between D3110-D3999] or restorative [covered codes only between D2140-D2999] procedures are not a Benefit for teeth to be retained for overdentures.

14. Partial dentures [covered codes only between D5211-5214, D5221-D5224] are not a Benefit to replace missing 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for a partial denture with cast clasps or rests.

15. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth [covered codes only between D8000-D8999], periodontal splinting [D4322-D4323)], gnathologic recordings, equilibration [D9952] or treatment of disturbances of the TMJ [covered codes only between D0310-D0322, D7810-D7899], unless included in *Schedule A*.

16. Porcelain denture teeth, or fixed partial dentures (overlays, implants, and appliances associated therewith) [D6940, D6950] and personalization and characterization of complete and partial dentures.

17. Extraction of teeth [D7111, D7140, D7210, D7220-D7240, D7241, D7250], when teeth are asymptomatic/ non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars.

18. TMJ dysfunction treatment modalities that involve prosthodontia [D5110-D5224, D6211-D6245, D6251, D6721-D6791], orthodontia [covered codes only between D8000–D8999], and full or partial occlusal rehabilitation or TMJ dysfunction procedures [covered codes only between D0310-D0322, D7810-D7899] solely for the treatment of bruxism.

19. Vestibuloplasty/ridge extension procedures [D7340, D7350] performed on the same date of service as extractions [D7111-D7250] on the same arch.

20. Deep sedation/general anesthesia [D9222, D9223] for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for intravenous conscious sedation/analgesia [D9239, D9243].

21. Intravenous conscious sedation/analgesia [D9239, D9243] for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for deep sedation/general anesthesia [D9222, D9223].

22. Inhalation of nitrous oxide [D9230] when administered with other covered sedation procedures.

23. Cosmetic dental care [exclude covered codes in this list if done for purely cosmetic reasons: D2330-D2394, D2710–D2751, D2940, D6211-D6245, D6251, D6721-D6791, D8000-D8999].

Medically Necessary Orthodontics for Pediatric Enrollees

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

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

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

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

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

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

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

5. The Benefit for a pre-orthodontic treatment examination [D8660] includes needed oral/facial photographic images [D0350, D0351, D0703, D0704]. Neither the Enrollee nor the plan may be charged for D0350 or D0351, D0703 or D0704 in conjunction with a pre-orthodontic treatment examination.

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

   a. Handicapping malocclusion - Eight (8) quarterly visits;
   b. Cleft palate or craniofacial anomaly - Six (6) quarterly visits for treatment of primary dentition;
   c. Cleft palate or craniofacial anomaly - Eight (8) quarterly visits for treatment of mixed dentition; or
   d. Cleft palate or craniofacial anomaly - Ten (10) quarterly visits for treatment of permanent dentition.
   e. Facial growth management – Four (4) quarterly visits for treatment of primary dentition;
   f. Facial growth management – Five (5) quarterly visits for treatment of mixed dentition;
   g. Facial growth management – Eight (8) quarterly visits for treatment permanent dentition.

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

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

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

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

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

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

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

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

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

11. The removal of fixed orthodontic appliances [D8680] for reasons other than completion of treatment is not a covered Benefit.

SCHEDULE C

Information Concerning Benefits Under The DeltaCare USA Plan

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

<table>
<tr><th colspan="2">SUMMARY CHART</th></tr>
<tr><td>(A) Deductibles</td><td>None</td></tr>
<tr><td>(B) Lifetime Maximums</td><td>None</td></tr>
<tr><td>(C) Out-of-Pocket Maximum</td><td>Individual $350.00
Multiple Child $700.00</td></tr>
<tr><td>(D) Professional Services</td><td>An Enrollee may be required to pay a Copayment amount for each procedure as shown in Schedule A, Description of Benefits and Copayments for Pediatric Enrollees, subject to the limitations and exclusions of this Plan.

Copayments range by category of service.
Examples are as follows:

Diagnostic Services: No Charge
Preventive Services: No Charge
Restorative Services: $ 20.00 - $ 310.00
Endodontic Services: $ 20.00 - $ 365.00
Periodontic Services: $ 10.00 - $ 350.00
Prosthodontic Services, (removable): $ 20.00 - $ 350.00
Maxillofacial Prosthetics: $ 35.00 - $ 350.00
Implant Services (medically necessary only): $ 25.00 - $ 350.00
Prosthodontic Services, (fixed): $ 40.00 - $ 300.00
Oral and Maxillofacial Surgery: $ 30.00 - $ 350.00
Orthodontic Services (medically necessary only): $ 350.00 - $ 350.00
Adjunctive General Services: No Charge - $ 210.00

NOTE: Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to one in a 6-month period.</td></tr>
<tr><td>(E) Outpatient Services</td><td>Not Covered</td></tr>
<tr><td>(F) Hospitalization Services</td><td>Not Covered</td></tr>
<tr><td>(G) Emergency Dental Coverage</td><td>Benefits for Emergency Dental Services by an Out-of-Network Dentist are limited to necessary care to stabilize the Enrollee’s condition and/or provide palliative relief.</td></tr>
<tr><td>(H) Ambulance Services</td><td>Not Covered</td></tr>
<tr><td>(I) Prescription Drug Services</td><td>Not Covered</td></tr>
<tr><td>(J) Durable Medical Equipment</td><td>Not Covered</td></tr>
<tr><td>(K) Mental Health Services</td><td>Not Covered</td></tr>
<tr><td>(L) Chemical Dependency Services</td><td>Not Covered</td></tr>
<tr><td>(M) Home Health Services</td><td>Not Covered</td></tr>
<tr><td>(N) Other</td><td>Not Covered</td></tr>
</table>

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

HIPAA Notice of Privacy Practices

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Our privacy practices reflect applicable federal law as well as state law. The privacy laws of a particular state or other federal laws might impose a stricter privacy standard. If these stricter laws apply and are not superseded by federal preemption rules under the Employee Retirement Income Security Act of 1974, the Plans will comply with the stricter law.

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

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

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

PERMITTED USES AND DISCLOSURES OF YOUR PHI

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

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

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

Permitted uses and disclosures without an authorization

We are permitted to disclose your PHI upon your request, or to your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with the law, and when otherwise required by law. We may disclose your PHI without your prior authorization in response to the following:

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

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

Disclosures made with your authorization

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

YOUR RIGHTS REGARDING PHI

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

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

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

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

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

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

You have the right to request or receive confidential communications from us by alternative means or at a different address.
You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request.

We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

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

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

You have the right to be notified following a breach of unsecured protected health information.

We will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

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

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

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

DeltaCare USA
PO Box 1803
Alpharetta, GA 30023-1803

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Non-Discrimination Disclosure

Discrimination is Against the Law

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

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

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

DeltaCare USA
PO Box 1803
Alpharetta, GA 30023-1803
1-800-422-4234
deltadentalins.com

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

ENROLLEE NOTICES

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

Federal Notices:

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

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

- **Notice of Non-Discrimination:** We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. If you believe we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

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

State Notices:

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

- **CA Grievance Process:** This notice describes our procedure for processing and resolving enrollee grievances and gives the address and phone number to make a complaint. Californians are encouraged to read this notice when they first enroll and annually thereafter.

- **CA Timely Access to Care:** California law requires heath plans to provide timely access to care. This law sets limits on how long enrollees have to wait to get appointments and telephone assistance.
- **CA Tissue and Organ Donations:** This notice informs subscribers of the societal benefits of organ donation and the methods they can use to become organ and/or tissue donors. California regulations require every health plan to provide this information upon enrollment and annually thereafter.

For questions concerning the notices, please contact us at 800-422-4243. You may also write to us at:

DeltaCare USA
PO Box 1803
Alpharetta, GA 30023-1803

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

OHCA Contract Notice for Fully Insured Groups

Delta Dental of California ("Delta Dental") and the fully insured Group Health Plan ("Contractholder") participate in an Organized Health Care Arrangement (as defined in 45 Code of Federal Regulations (C.F.R.) §164.501) ("OHCA"). The Contractholder hereby certifies that:

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- In order for PHI beyond summary health information to be disclosed, the fully insured Contractholder must: (1) provide a signed attestation that their plan documents have been amended to comply with the applicable HIPAA privacy administrative safeguard provisions; (2) have issued a HIPAA compliant privacy notice; and (3) provide individuals with the right to access, review, amend, and receive an accounting of disclosures.

- PHI requested is the minimum necessary for the Contractholder to perform its health care operations and/or payment activities related to the Contract herein.

- If Delta Dental is directed to release PHI to a third party, the third party has a HIPAA compliant BAA with the Contractholder.