

Family Dental HMO

for Small Businesses

Thank you for considering DeltaCare[®] USA for your dental coverage. When it comes to dental benefits, making the right choice doesn't have to be complicated. DeltaCare USA plans are easy to use, and offer a great combination of affordability and dentist choice. Learn how DeltaCare USA plans work, and how they could be a part of your strategies to keep both your employees and your bottom line healthy.

With DeltaCare USA, there are no claim forms to submit.

	Select a DeltaCare USA dentist
	Receive your welcome kit
	Schedule an appointment
	Receive dental care
	Pay only your copayment directly to dentist

**No paperwork.
No hassle.**

About DeltaCare USA

Upon enrollment, enrollees receive a list of dental procedures that show their share of the cost for covered services when provided by their selected DeltaCare USA network dentist. This share of the costs is called a copayment. Enrollees must visit their selected DeltaCare USA dentist in order to receive benefits. They are responsible only for the copayment for each procedure at the time of treatment.

In addition to knowing procedure costs up front, DeltaCare USA plans also provide other advantages. The plans do not require enrollees to satisfy a deductible, so they can start saving on out-of-pocket costs immediately. And with no annual maximum limitations, enrollees can use their DeltaCare USA benefits all year long.

Plan features

- DeltaCare USA plans include no deductibles and no annual benefit maximums for covered services.
- Low or no copayments for many services such as cleanings and exams help keep smiles healthy by encouraging regular checkups and cleanings.
- No claim forms to fill out – patients just pay their DeltaCare USA dentist the copayment amount at the time of service.
- Easy-to-use DeltaCare USA dental plans provide a great balance of network dentist choice and affordability.

Underwritten by
Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

Administered By
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023

Customer Service
800-471-8148
deltadentalins.com

Dentists you can trust

- A network of private practice dental facilities that have been carefully screened for quality care and best practices
- A large choice of dentists and low network turnover so that patients can enjoy a long-term relationship with their network dentist
- Easy access to specialty care — DeltaCare USA network dentists will coordinate care if enrollees require treatment from a specialist for services covered under the plan

DeltaCare USA plans offer many advantages

Select a DeltaCare USA plan for these great features:

- **Coverage that can give you peace of mind.** Our plans include no restrictions on pre-existing conditions (except for work in progress) and out-of-area dental emergency coverage.
- **Online services that make getting information quick and easy.** Wherever you are — work, home or on the go — you and your employees can manage your account with such timesaving features as viewing eligibility, benefits and claims or locating a network dentist. Our online tools are also a snap to use on a mobile device, so we're there when you need us.
- **The SmileWay® Wellness Program** provides resources including a risk assessment quiz, articles, videos and a subscription to *Grin!*, our free dental health e-newsletter.
- **It's easy to change DeltaCare USA dentists.** Enrollees may change their selected network dentist at deltadentalins.com or by notifying us by phone or in writing. Requests made by the 21st of the month will become effective the first of the following month.

This benefit information is only a summary and not intended or designed to replace or serve as the Evidence of Coverage. To view the complete list of covered services and copayments, plus limitations and exclusions contained in the Evidence of Coverage [click here](#) or call 800-471-8148. In the event of any inconsistency between this document and the Evidence of Coverage, the terms of the Evidence of Coverage will prevail.

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Plan Highlights

Deductible & Maximums	Pediatric Enrollees (up to age 19)	Adults (age 19 and older)
Deductible	Enrollee	None
	Family	None
Annual Maximum	None	None
Out-of-Pocket Maximum <i>After this amount is reached, the plan pays 100% of the remaining covered services for that contract year.</i>	\$350 one pediatric enrollee	None
	\$700 two or more pediatric enrollees	

DeltaCare USA provides great dental benefits and predictable costs. The plan provides a full list of copayments¹ so the cost for covered services is never a surprise. Copayments for some of the most common services are listed below.

Sample of Covered Services²

Category	Procedure Code and Description ³	Copayment Amount ¹	
		Pediatric Enrollees (up to age 19)	Adults (age 19 and older)
Diagnostic & Preventive Services (D & P)	D0999 - Office visit	No Cost	No Cost
	D0120 - Periodic oral exam – established patient	No Cost	No Cost
	D0150 - Comprehensive oral evaluation – new or established patient	No Cost	No Cost
	D0210 - Complete series of x-rays	No Cost	No Cost
	D0220 - Periapical x-ray of tooth's root	No Cost	No Cost
	D0230 - Periapical x-ray of tooth's root, each additional image	No Cost	No Cost
	D0272 - Bitewing x-rays (2 images)	No Cost	No Cost
	D0274 - Bitewing x-rays (4 images)	No Cost	No Cost
	D0330 - Panoramic x-ray	No Cost	No Cost
	D1110 - Prophylaxis (cleaning) – adult	No Cost	No Cost
	D1120 - Prophylaxis (cleaning) – child	No Cost	Not a benefit
	D1208 - Fluoride treatment	No Cost	Not a benefit
	D1351 - Sealant – per tooth	No Cost	Not a benefit

Category	Procedure Code and Description ³	Copayment Amount ¹	
		Pediatric Enrollees (up to age 19)	Adults (age 19 and older)
Basic Services	D2140 - Amalgam (silver-colored) filling – 1 surface	\$25	\$25
	D2150 - Amalgam (silver-colored) filling – 2 surfaces	\$105	\$35
	D2160 - Amalgam (silver-colored) filling – 3 surfaces	\$110	\$40
	D2330 - Resin (tooth-colored) filling, front tooth, 1 surface	\$115	\$50
	D2331 - Resin (tooth-colored) filling, front tooth, 2 surfaces	\$120	\$60
	D2332 - Resin (tooth-colored) filling, front tooth, 3 surfaces	\$135	\$70
	D2391 - Resin (tooth-colored) filling, back tooth, 1 surface	Not a benefit	\$75
	D2392 - Resin (tooth-colored) filling, back tooth, 2 surfaces	Not a benefit	\$85
	D2393 - Resin (tooth-colored) filling, back tooth, 3 surfaces	Not a benefit	\$120
Endodontics	D3310 - Root canal, front tooth	\$300	\$300
	D3320 - Root canal, bicuspid tooth	\$300	\$300
	D3330 - Root canal, molar tooth	\$300	\$300
Periodontics	D4260 - Periodontal surgery, per quadrant	\$350	\$350
	D4341 - Periodontal scaling and root planing – four or more teeth per quadrant	\$115	\$115
	D4910 - Periodontal maintenance	Not a benefit	\$15
Oral Surgery	D7140 - Extraction (removal) of a fully exposed tooth	\$65	\$65
	D7210 - Surgical extraction or erupted (exposed) tooth	\$165	\$80
	D7240 - Extraction (removal) of fully impacted tooth, completely bony	\$160	\$160
Major Services	D2750 - Crown, porcelain and precious metal	\$350	\$350
	D2790 - Crown, precious metal	\$350	\$350
	D5110 - Full upper denture	\$350	\$350
	D6240 - Bridge pontic, porcelain and precious metal	\$300	\$350
	D6750 - Bridge crown, porcelain and precious metal	\$350	\$350
Orthodontics	D8080 - Pediatric services – Medically necessary only	\$350	Not a benefit
	D8090 - Adult services	Not a benefit	\$3,250

¹ A copayment is the amount the enrollee pays for covered services at the time of treatment.

² Benefits featured above represent the most frequently used services covered under your plan; other services are also covered. After enrollment, the DeltaCare USA plan will make available a complete list of covered services and copayments, along with any limitations and exclusions that apply.

³ Copayments and procedure descriptions referenced above are intended to clarify the delivery of benefits under the DeltaCare USA plan and are not to be interpreted as CDT-2014 descriptors or nomenclature, which are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

DeltaCare[®] USA



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Family Dental HMO

Provided by:

Delta Dental of California
17871 Park Plaza Dr. Ste 200
Cerritos, CA 90703

Administered by:

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, Georgia 30023
800-471-7583

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IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at the Member/Customer Service telephone number on the back of your Delta Dental ID card, or 1-800-471-7583.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda gratuita, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Delta Dental o al 1-800-471-7583.

重要通知： 您能讀懂這封信嗎？ 如果不能， 我們可以請人幫您閱讀。 這封信也可以用您所講的語言書寫。 如需幫助， 請立即撥打登列在您的Delta Dental ID卡背面上的會員/客戶服務部的電話， 或者撥打電話 1-800-471-7583。

INTRODUCTION

We are pleased to welcome you to the DeltaCare[®] USA dental plan. Your employer has chosen to participate in the Exchange, and you have selected Delta Dental of California ("Delta Dental") to meet your dental insurance needs. This plan is underwritten by Delta Dental and administered by Delta Dental Insurance Company.

Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the Dentist but to see him or her on a regular basis.

Eligibility is determined by your employer. The plan provides dental Benefits for adults and children as defined in the following sections:

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

Using This Combined Evidence of Coverage and Disclosure Form (EOC)

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

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 the 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. "We," "us" and "our" always refer to Delta Dental or the 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 section entitled "Special Needs".

Identification Number

Please provide the Enrollee's identification ("ID") number to your Dentist whenever you receive dental services. ID cards are not required. If you wish to have an ID card, you may obtain one by visiting our website at deltadentalins.com.

This EOC is *not* a Summary Plan Description to meet the requirements of ERISA.

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

Contact Us - For more information, please visit our website at deltadentalins.com or call our Customer Service Center at 800-471-7583. If you prefer to write us with your question(s), please mail your inquiry to the following address:

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



Anthony S. Barth, Executive Vice President / Chief Operating Officer

NOTICE: THIS EOC CONSTITUTES ONLY A SUMMARY OF YOUR GROUP DENTAL PLAN AND ITS ACCURACY SHOULD BE VERIFIED BEFORE RECEIVING TREATMENT. AS REQUIRED BY THE CALIFORNIA HEALTH & 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.

DEFINITIONS

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

Administrator: Delta Dental Insurance Company or other entity designated by Delta Dental, operating as an Administrator in the state of California. Certain functions described throughout this EOC may be performed by the Administrator, as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-471-7583.

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

Benefits: covered 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 Dentist who provides services in general dentistry and who has agreed to provide Benefits under the plan.

Contract Orthodontist: a Dentist who specializes in orthodontics and who has agreed to provide Benefits under the plan.

Contract Specialist: a Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under the plan.

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

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

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

Copayment: the amount listed in the Schedules and charged to an Enrollee by a Contract Dentist or Contract Specialist for the Benefits provided under the plan. Copayments must be paid at the time treatment is received.

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

Effective Date: the original date the Contract starts.

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

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

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

Emergency Services: care provided by a Dentist to treat a dental condition which manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the Enrollee to result in either: 1) placing the Enrollee's dental health in serious jeopardy, or 2) serious impairment to dental functions.

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

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

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

Exchange: the California Exchange also referred to as "Covered California."

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

Optional: any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, 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 Delta Dental to provide Benefits under the terms of the Contract.

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

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

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

Qualifying Status Change:

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

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

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 the Dentist's facility because of a physical disability and 2) the Enrollee's inability to comply with the Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

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

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

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

Treatment in Progress: any single dental procedure, as defined by the CDT Code, that has been started while the Enrollee was eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not the Enrollee continues to be eligible for Benefits under the DeltaCare USA plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established, full or partial dentures for which an impression has been taken and orthodontics when bands have been placed and tooth movement has begun.

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

ELIGIBILITY AND ENROLLMENT

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

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

Eligibility Requirement for Pediatric Benefits

Pediatric Enrollees eligible for Pediatric Benefits are:

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

Eligibility Requirement for Adult Benefits

Adult Enrollees eligible for Adult Benefits are:

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

A dependent child 26 years of age or older may continue eligibility for Adult Benefits if:

- he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
- he or she is chiefly dependent on the Primary Enrollee or Spouse for support; and
- proof of dependent's disability is provided within 60 days of request. Such requests will not be made more than once a year following a two (2) year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Primary Enrollee or Spouse for support because of a mental or physical disability that began before he or she reached the limiting age.

Enrollment

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

Eligible Employees may enroll for coverage during the Open Enrollment Period or due to a Qualifying Status Change.

Dependents on active military duty are not eligible.

Termination of Coverage

The Primary Enrollee has the right to terminate coverage by sending Delta Dental or the Exchange written notice of intent to terminate. The effective date of a requested termination will be at least 14 days from the date of Delta Dental's receipt of the request for termination. Delta Dental will notify the Contractholder of any requests for termination received from Primary Enrollees. If coverage is terminated because the Enrollee is covered by Medicaid, the last day of coverage with Delta Dental is the day before the new coverage is effective.

An Enrollee loses eligibility when he or she is no longer reported eligible by the Exchange or eligible under the terms of the Contract. If termination is due to loss of eligibility through the Exchange, termination is effective the last day of the month following the month of termination.

We may cancel the Contract 31 days after written notice to the Contractholder if premiums are not paid when due. The Contractholder will be given a 31 day grace period, which begins immediately following the last day of paid coverage, or 31 days from the date of notice, whichever is later, to pay the monthly premium. During that time, Delta Dental will continue to provide coverage to Enrollees. If the premium remains unpaid at the end of the 31 day grace period, the Contractholder will notify you that coverage has terminated along with the date of termination. We may also cancel an Enrollee's enrollment if we demonstrate that the Enrollee committed fraud or an intentional misrepresentation of material fact in obtaining Benefits under this plan.

We will not pay for services received after the Enrollee's coverage ends. However for treatment in progress, we will continue to provide Benefits less any applicable Copayment.

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.

Strike, Lay-off and Leave of Absence

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

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

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

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

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

Continued Coverage under USERRA

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

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

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

Continuation of Coverage Under COBRA

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

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

Continuation of Coverage Under Cal-COBRA

Cal-COBRA (the California Continuation Benefits Replacement Act), pertaining to certain employers with two (2) to 19 employees, provides a way for you and your Dependent Enrollees who lose employer-sponsored group health coverage ("Qualified Beneficiary" to continue coverage for a period of time. We agree to provide the Benefits to Enrollees who elect continued coverage pursuant to this section, provided:

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

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

OVERVIEW OF DENTAL BENEFITS

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

What is the DeltaCare USA Plan?

The DeltaCare USA Plan provides Pediatric Benefits and Adult Benefits through a convenient network of Contract Dentists in the state of California. These Dentists are screened to ensure that our standards of quality, access and safety are maintained. The network is composed of established dental professionals. When you visit your assigned Contract Dentist, you pay only the applicable Copayment 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. Benefits are only available in the state of California. The services are performed as deemed appropriate by your attending Contract Dentist.

Copayments and Other Charges

You are required to pay any Copayments listed in the Schedules attached to this EOC. Copayments are paid directly to the Dentist who provides treatment. Charges for broken appointments and 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 provider contract contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental. Except for the provisions in “*Emergency Services*”, if you have not received Preauthorization for treatment from an Out-of-Network Dentist, and we fail to pay that Out-of-Network Dentist, you may be liable to that Dentist for the cost of services. For further clarification, see “*Emergency Services*” and “*Specialist Services*”.

Non-Covered Services

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating Dentist may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Customer Service at 800-471-7583. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

Coordination of Benefits

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

How do we determine which Plan is the “primary” plan?

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

- a) secondary to the plan covering the insured person as a dependent; and
 - b) primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.
- (3) Except as stated in paragraph (4), when this plan and another plan cover the same child as a dependent of different persons, called parents:
- a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
 - b) if both parents have the same birthday, the benefits of the plan covering one parent longer are determined before those of the plan covering the other parent for a shorter period of time.
 - c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.
- (4) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody or as a dependent of the custodial parent's spouse (i.e. step-parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree establishing financial responsibility for the health care expenses with respect to the child, the benefits of a plan covering the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy covering the child as a dependent child.
- (5) If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in paragraph (3).
- (6) The benefits of a plan covering an insured person as an employee who is neither laid-off nor retired are determined before those of a plan covering that insured person as a laid-off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (6) is ignored.
- (7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination.
- a) First, the benefits of a plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent).
 - b) Second, the benefits under the continuation coverage.
 - c) If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule (7) is ignored.
- (8) If none of the above rules determines the order of benefits, the benefits of the plan covering an employee longer are determined before those of the plan covering that insured person for the shorter term.
- (9) When determination cannot be made in accordance with the above for Pediatric Benefits, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental only plan.

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

Delta Dental shall provide Contract Dentists at convenient locations. Upon enrollment, Delta Dental will assign the Enrollee to a Contract Dentist facility. The Primary Enrollee may request changes to the assigned Contract Dentist facility by contacting Customer Service Center at 800-471-7583. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. The 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 written notice of assignment to another Contract Dentist facility near the Enrollee's home if: 1) a requested facility is closed to further enrollment; 2) a chosen Contract Dentist facility withdraws from the plan; or 3) an assigned facility requests, for good cause, that the Enrollee be re-assigned to another facility.

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

All services which are Benefits shall be rendered at the Contract Dentist facility assigned to the Enrollee. Delta Dental shall have no obligation or liability with respect to services rendered by Out-of Network Dentists, with the exception of Emergency Services or Specialist Services recommended by a Contract Dentist, and preauthorized in writing by Delta Dental. All preauthorized Specialist Services claims will be paid by Delta Dental less any applicable Copayments. A Contract Dentist may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services.

If your assigned Contract Dentist facility terminates participation in the plan, that Contract Dentist facility will complete all Treatment in Progress as described above. 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.

Delta Dental shall give written notice to the Enrollee within a reasonable time of any termination or breach of contract, or inability to perform by any Contract Dentist if the Enrollee will be materially or adversely affected.

Continuity of Care

If you are a current Enrollee, you may have the right to obtain completion of care under this 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 this 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, contact our Customer Service Center at 800-471-7583. You may also contact us to request a copy of Delta Dental's Continuity of Care Policy. Delta Dental is not required to continue care with the Dentist if you are not eligible under this Contract or if Delta Dental 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 Services

The assigned Contract Dentist facility maintains a 24 hour Emergency Services system seven (7) days a week. If Emergency Services are needed, you should contact the Contract Dentist facility whenever possible. If you are unable to reach the Contract Dentist facility for Emergency Services, you should call the Customer Service Center at 800-471-7583 for assistance in obtaining urgent care. During non-business hours or if you require Emergency Services and are 35 miles or more from your assigned Contract Dentist facility, you do not need to call for referral and may seek treatment from a Dentist other than at the assigned Contract Dentist facility. You are responsible for the Copayment(s) for any treatment received due to an emergency. Emergency dental care is limited to necessary care to stabilize your condition and/or provide palliative relief when you:

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

Further treatment must be obtained from the assigned Contract Dentist facility.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics or pediatric dentistry must be: 1) referred by the assigned Contract Dentist; and 2) preauthorized in writing by us. You pay the specified Copayment. (Refer to the Schedules attached to this EOC.)

If you require Specialist Services and there is no Contract Specialist to provide these services within 35 miles of your home address, the assigned Contract Dentist must receive Preauthorization from Delta Dental to refer you to an Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist that are not preauthorized by Delta Dental may not be covered.

If the services of a Contract Orthodontist are needed, please refer to the Schedules attached to this EOC to determine Benefits.

Claims for Reimbursement

Claims for covered Emergency Services or preauthorized 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. The address for claims submission is Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Provider Compensation

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

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

Processing Policies

The dental care guidelines for the DeltaCare USA plan explain to Contract Dentists what services are covered under the dental Contract. Contract Dentists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist that fall under the scope of Benefits of the dental plan are provided subject to any Copayments. If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a specialist. An Enrollee may contact Delta Dental's Customer Service department at 800-471-7583 for information regarding the dental care guidelines for DeltaCare USA.

Second Opinions

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

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service department at 800-471-7583 or write to Delta Dental.

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

Special Needs

If you believe you have a Special Health Care Need, you should contact our Customer Service department at 800-471-7583. We will confirm whether such a Special Health Care Need exists and what arrangements can be made to assist you in obtaining Benefits. We will not be responsible for the failure of any Dentist to comply with any law or regulation concerning treatment of persons with Special Health Care Needs which is applicable to the Dentist.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service department at 800-471-7583.

ENROLLEE COMPLAINT PROCEDURE

Delta Dental or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the Administrator or the quality of dental services performed by a Contract Dentist, you may call the Customer Service Center at 800-471-7583, or the complaint may be addressed in writing to:

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

Written communication must include: 1) the name of the patient; 2) the name, address, telephone number and ID number of the Enrollee; and 3) the 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 shall include a complaint, dispute, request for reconsideration or appeal made by Pediatric Enrollee or the Enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall 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 5 calendar days of the receipt of any complaint, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. If the complaint involves severe pain and/or imminent and serious threat to a patient's dental health, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the grievance within three days.

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

The Department 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 **1-800-471-7583** and use our grievance process before

contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **1-888-HMO-2219** and a TDD line **1-877-688-9891** for the hearing and speech impaired. The Department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

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

Complaints Involving an Adverse Benefit Determination

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) the Enrollee must file a request for review (a complaint) with Delta Dental within at least 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide the Enrollee with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

GENERAL PROVISIONS

Public Policy Participation by Enrollees

Delta Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment program reports and communication from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to:

Delta Dental of California
Customer Service Center
P.O. Box 1803
Alpharetta, GA 30023

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 the 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 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.

Third Party Administrator (“TPA”)

Delta Dental 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 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.

Organ and Tissue Donation

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

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

The Benefits shown below are performed as needed and deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the 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 the DeltaCare® USA plan and is not to be interpreted as CDT-2014 procedure codes, descriptors or nomenclature which is under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

Pediatric Enrollee.....	\$350.00 each Contract Year
Multiple Pediatric Enrollees.....	\$700.00 each Contract Year

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

If more than one Pediatric Enrollee is covered under this Contract, the financial obligation for Benefits is not more than the OOPM for multiple Pediatric Enrollees. After a Pediatric Enrollee meets his or her OOPM, he or she will have no further payment for the remainder of the Contract Year for 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 Benefits.

Delta Dental recommends that the Pediatric Enrollee or other party responsible keep a record of payment for Benefits. If you have any questions regarding your OOPM, please contact the Customer Service department at 800-471-7583.

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D0100–D0999 I. DIAGNOSTIC					
D0999	Unspecified diagnostic procedure, by report	No Cost	No Cost	<i>Includes office visit, per visit (in addition to other services)</i>	<i>Includes office visit, per visit (in addition to other services)</i>
D0120	Periodic oral evaluation - established patient	No Cost	No Cost		
D0140	Limited oral evaluation - problem focused	No Cost	No Cost		
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost	Not a benefit		
D0150	Comprehensive oral evaluation - new or established patient	No Cost	No Cost		
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost	No Cost		

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost	No Cost		
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost	No Cost		
D0190	Screening of a patient	No Cost	Not a benefit		
D0191	Assessment of a patient	No Cost	Not a benefit		
D0210	Intraoral - complete series of radiographic images	No Cost	No Cost	<i>Limited to 1 every 24 consecutive months</i>	<i>Limited to 1 every 24 consecutive months</i>
D0220	Intraoral - periapical first radiographic image	No Cost	No Cost		
D0230	Intraoral - periapical each additional radiographic image	No Cost	No Cost		
D0240	Intraoral - occlusal radiographic image	No Cost	No Cost		
D0250	Extraoral - first radiographic image	Not a benefit	No Cost		
D0260	Extraoral - each additional radiographic image	Not a benefit	No Cost		
D0270	Bitewing - single radiographic image	No Cost	No Cost		
D0272	Bitewings - two radiographic images	No Cost	No Cost		
D0273	Bitewings - three radiographic images	No Cost	No Cost		
D0274	Bitewings - four radiographic images	No Cost	No Cost		<i>Limited to 1 series every 6 months</i>
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost	No Cost		
D0330	Panoramic radiographic image	No Cost	No Cost	<i>Limited to 1 every 24 consecutive months</i>	<i>Limited to 1 every 24 consecutive months</i>
D0460	Pulp vitality tests	No Cost	No Cost		
D0470	Diagnostic casts	No Cost	No Cost		
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Not a benefit	No Cost		<i>Available only when performed in conjunction with a covered biopsy</i>
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not a benefit	No Cost		<i>Available only when performed in conjunction with a covered biopsy</i>
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Not a benefit	No Cost		<i>Available only when performed in conjunction with a covered biopsy</i>
D0601	Caries risk assessment and documentation, with a finding of low risk	No Cost	Not a benefit		<i>Limited to age 3 to 18; limited to 1 per 36 month period when performed by the same Contract Dentist or office</i>

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No Cost	Not a benefit		Limited to age 3 to 18; limited to 1 per 36 month period when performed by the same Contract Dentist or office
D0603	Caries risk assessment and documentation, with a finding of high risk	No Cost	Not a benefit		Limited to age 3 to 18; limited to 1 per 36 month period when performed by the same Contract Dentist or office

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis - adult	No Cost	No Cost	Cleaning; 2 per 12 month period	Cleaning; 2 per 12 month period
D1110	(Additional cleaning) Prophylaxis - adult	Not a benefit	No Cost		Within the 12 month period
D1120	Prophylaxis - child	No Cost	Not a benefit	Cleaning; 2 per 12 month period	
D1206	Topical application of fluoride varnish	No Cost	Not a benefit	2 per 12 month period	
D1208	Topical application of fluoride	No Cost	Not a benefit	2 per 12 month period	
D1310	Nutritional counseling for control of dental disease	No Cost	No Cost		
D1330	Oral hygiene instructions	No Cost	Not a benefit		
D1351	Sealant - per tooth	No Cost	Not a benefit	Limited to permanent first and second molars without restorations or decay	
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	No Cost	Not a benefit	Limited to permanent first and second molars without restorations or decay	
D1510	Space maintainer - fixed - unilateral	No Cost	Not a benefit		
D1515	Space maintainer - fixed - bilateral	No Cost	Not a benefit		
D1520	Space maintainer - removable - unilateral	No Cost	Not a benefit		
D1525	Space maintainer - removable - bilateral	No Cost	Not a benefit		
D1550	Re-cementation of space maintainer	No Cost	Not a benefit		
D1555	Removal of fixed space maintainer	No Cost	Not a benefit	Included in case by Dentist who placed appliance	

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	\$25	\$25		
D2150	Amalgam - two surfaces, primary or permanent	\$105	\$35		
D2160	Amalgam - three surfaces, primary or permanent	\$110	\$40		

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D2161	Amalgam - four or more surfaces, primary or permanent	\$115	\$45		
D2330	Resin-based composite - one surface, anterior	\$115	\$50		
D2331	Resin-based composite - two surfaces, anterior	\$120	\$60		
D2332	Resin-based composite - three surfaces, anterior	\$135	\$70		
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	\$165	\$80		
D2390	Resin-based composite crown, anterior	\$200	\$110		
D2391	Resin-based composite - one surface, posterior	Not a benefit	\$75		
D2392	Resin-based composite - two surfaces, posterior	Not a benefit	\$85		
D2393	Resin-based composite - three surfaces, posterior	Not a benefit	\$120		
D2394	Resin-based composite - four or more surfaces, posterior	Not a benefit	\$125		
D2510	Inlay - metallic - one surface	Not a benefit	\$210		
D2520	Inlay - metallic - two surfaces	Not a benefit	\$220		
D2530	Inlay - metallic - three or more surfaces	Not a benefit	\$230		
D2542	Onlay - metallic - two surfaces	Not a benefit	\$310		
D2543	Onlay - metallic - three surfaces	\$350	\$350		
D2544	Onlay - metallic - four or more surfaces	\$350	\$350		
D2610	Inlay - porcelain/ceramic - one surface	Not a benefit	\$310		
D2620	Inlay - porcelain/ceramic - two surfaces	Not a benefit	\$335		
D2630	Inlay - porcelain/ceramic - three or more surfaces	Not a benefit	\$360		
D2642	Onlay - porcelain/ceramic - two surfaces	Not a benefit	\$320		
D2643	Onlay - porcelain/ceramic - three surfaces	Not a benefit	\$345		
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not a benefit	\$370		
D2650	Inlay - resin-based composite - one surface	Not a benefit	\$185		
D2651	Inlay - resin-based composite - two surfaces	Not a benefit	\$210		
D2652	Inlay - resin-based composite - three or more surfaces	Not a benefit	\$245		
D2662	Onlay - resin-based composite - two surfaces	Not a benefit	\$195		
D2663	Onlay - resin-based composite - three surfaces	Not a benefit	\$220		

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D2664	Onlay - resin-based composite - four or more surfaces	Not a benefit	\$255		
D2710	Crown - resin-based composite (indirect)	\$350	\$350		
D2712	Crown - 3/4 resin-based composite (indirect)	Not a benefit	\$145		
D2720	Crown - resin with high noble metal	Not a benefit	\$350		
D2721	Crown - resin with predominantly base metal	Not a benefit	\$300		
D2722	Crown - resin with noble metal	Not a benefit	\$350		
D2740	Crown - porcelain/ceramic substrate	\$350	\$350		
D2750	Crown - porcelain fused to high noble metal	\$350	\$350		
D2751	Crown - porcelain fused to predominantly base metal	\$300	\$300		
D2752	Crown - porcelain fused to noble metal	\$350	\$320		
D2780	Crown - 3/4 cast high noble metal	\$350	\$350		
D2781	Crown - 3/4 cast predominantly base metal	\$350	\$350		
D2782	Crown - 3/4 cast noble metal	\$350	\$350		
D2783	Crown - 3/4 porcelain/ceramic	\$350	\$350		
D2790	Crown - full cast high noble metal	\$350	\$350		
D2791	Crown - full cast predominantly base metal	\$350	\$350		
D2792	Crown - full cast noble metal	\$350	\$350		
D2910	Recement inlay, onlay, or partial coverage restoration	\$65	\$65		
D2915	Recement cast or prefabricated post and core	\$65	\$65		
D2920	Recement crown	\$65	\$65		
D2921	Reattachment of tooth fragment, incisal edge or cusp	Not a benefit	\$80		<i>Anterior tooth</i>
D2929	Prefabricated porcelain/ceramic crown – primary tooth	No Cost	Not a benefit	<i>Anterior tooth</i>	
D2930	Prefabricated stainless steel crown - primary tooth	\$200	\$200		
D2931	Prefabricated stainless steel crown - permanent tooth	\$170	\$170		
D2932	Prefabricated resin crown	\$170	Not a benefit	<i>When not used in conjunction with any other crown; anterior tooth</i>	
D2933	Prefabricated stainless steel crown with resin window	\$150	Not a benefit		
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	\$160	Not a benefit		
D2940	Protective restoration	\$30	\$30		
D2949	Restorative foundation for an indirect restoration	Not a benefit	\$120		

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D2950	Core buildup, including any pins when required	\$120	\$120		
D2951	Pin retention - per tooth, in addition to restoration	\$40	\$40		
D2952	Post and core in addition to crown, indirectly fabricated	\$160	\$160	<i>Base metal post; includes canal preparation</i>	<i>Base metal post; includes canal preparation</i>
D2953	Each additional indirectly fabricated post - same tooth	Not a benefit	\$70		<i>Includes canal preparation</i>
D2954	Prefabricated post and core in addition to crown	\$140	\$140	<i>Includes canal preparation</i>	<i>Includes canal preparation</i>
D2955	Post removal	\$130	Not a benefit		
D2970	Temporary crown (fractured tooth)	\$170	\$170		<i>Palliative treatment only</i>
D2971	Additional procedures to construct new crown under existing partial denture framework	Not a benefit	\$100		
D2980	Crown repair necessitated by restorative material failure	\$130	\$130		
D2981	Inlay repair necessitated by restorative material failure	No Cost	No Cost		
D2982	Onlay repair necessitated by restorative material failure	No Cost	No Cost		
D2983	Veneer repair necessitated by restorative material failure	Not a benefit	\$85		
D2990	Resin infiltration of incipient smooth surface lesions	No Cost	Not a benefit		
D3000-D3999 IV. ENDODONTICS					
D3110	Pulp cap - direct (excluding final restoration)	\$40	\$40		
D3120	Pulp cap - indirect (excluding final restoration)	\$45	\$45		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$85	\$85		
D3221	Pulpal debridement, primary and permanent teeth	\$90	\$90		
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root	\$120	Not a benefit		
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$120	Not a benefit		
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$110	Not a benefit		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	\$300	\$300	<i>Root canal; per canal</i>	<i>Root canal; per canal</i>

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	\$300	\$300	<i>Root canal; per canal</i>	<i>Root canal; per canal</i>
D3330	Endodontic therapy, molar (excluding final restoration)	\$300	\$300	<i>Root canal; per canal</i>	<i>Root canal; per canal</i>
D3331	Treatment of root canal obstruction; non-surgical access	Not a benefit	\$75		
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Not a benefit	\$65		
D3346	Retreatment of previous root canal therapy - anterior	\$350	\$350	<i>Per canal</i>	<i>Per canal</i>
D3347	Retreatment of previous root canal therapy - bicuspid	\$350	\$350	<i>Per canal</i>	<i>Per canal</i>
D3348	Retreatment of previous root canal therapy - molar	\$350	\$350	<i>Per canal</i>	<i>Per canal</i>
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	\$140	Not a benefit		
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	\$140	Not a benefit		
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	\$220	Not a benefit		
D3410	Apicoectomy - anterior	\$350	\$350	<i>Per canal</i>	<i>Per canal</i>
D3421	Apicoectomy - bicuspid (first root)	\$350	\$350	<i>Per canal</i>	<i>Per canal</i>
D3425	Apicoectomy - molar (first root)	\$350	\$350	<i>Per canal</i>	<i>Per canal</i>
D3426	Apicoectomy (each additional root)	\$150	\$150	<i>Per canal</i>	<i>Per canal</i>
D3427	Periradicular surgery without apicoectomy	\$350	\$350	<i>Per canal</i>	<i>Per canal</i>
D3430	Retrograde filling - per root	\$120	\$120		
D3450	Root amputation - per root	\$170	\$170		
D3920	Hemisection (including any root removal), not including root canal therapy	Not a benefit	\$55		
D4000-D4999 V. PERIODONTICS					
<i>- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.</i>					
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$150	\$150		

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$150	\$150		
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost	Not a benefit		
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$350	\$350		
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$280	\$280		
D4249	Clinical crown lengthening - hard tissue	Not a benefit	\$150		
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$350	\$350		
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$350	\$350		
D4270	Pedicle soft tissue graft procedure	Not a benefit	\$150		
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	Not a benefit	\$95		
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	Not a benefit	\$150		
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	Not a benefit	\$150		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	\$115	\$115		Limited to 4 quadrants during any 12 consecutive months
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	\$85	\$85		Limited to 4 quadrants during any 12 consecutive months
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$70	\$70		Limited to 1 treatment in any 12 consecutive months
D4910	Periodontal maintenance	Not a benefit	\$15		Limited to 2 treatments each 12 month period
D4910	(Additional) Periodontal maintenance	Not a benefit	\$25		Within the 12 month period

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	\$50	Not a benefit		
D4921	Gingival irrigation – per quadrant	Not a benefit	No Cost		
D5000-D5899 VI. PROSTHODONTICS (removable)					
D5110	Complete denture - maxillary	\$350	\$350		
D5120	Complete denture - mandibular	\$350	\$350		
D5130	Immediate denture - maxillary	\$350	\$350		
D5140	Immediate denture - mandibular	\$350	\$350		
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$350	\$350		
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$350	\$350		
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$350	\$350		
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$350	\$350		
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not a benefit	\$350		
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not a benefit	\$350		
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	\$350	Not a benefit		
D5410	Adjust complete denture - maxillary	\$50	\$50		
D5411	Adjust complete denture - mandibular	\$50	\$50		
D5421	Adjust partial denture - maxillary	\$45	\$50		
D5422	Adjust partial denture - mandibular	\$50	\$50		
D5510	Repair broken complete denture base	\$100	\$100		
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$80	\$80		
D5610	Repair resin denture base	\$100	\$100		
D5620	Repair cast framework	\$130	\$130		
D5630	Repair or replace broken clasp	\$110	\$110		

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D5640	Replace broken teeth - per tooth	\$90	\$90		
D5650	Add tooth to existing partial denture	\$100	\$100		
D5660	Add clasp to existing partial denture	\$120	\$120		
D5710	Rebase complete maxillary denture	\$350	\$350		
D5711	Rebase complete mandibular denture	\$350	\$350		
D5720	Rebase maxillary partial denture	\$305	\$305		
D5721	Rebase mandibular partial denture	\$305	\$305		
D5730	Reline complete maxillary denture (chairside)	\$210	\$210		
D5731	Reline complete mandibular denture (chairside)	\$210	\$210		
D5740	Reline maxillary partial denture (chairside)	\$195	\$195		
D5741	Reline mandibular partial denture (chairside)	\$195	\$195		
D5750	Reline complete maxillary denture (laboratory)	\$210	\$210		
D5751	Reline complete mandibular denture (laboratory)	\$210	\$210		
D5760	Reline maxillary partial denture (laboratory)	\$210	\$210		
D5761	Reline mandibular partial denture (laboratory)	\$210	\$210		
D5820	Interim partial denture (maxillary)	Not a benefit	\$250		Limited to 1 in any 12 consecutive months
D5821	Interim partial denture (mandibular)	Not a benefit	\$250		Limited to 1 in any 12 consecutive months
D5850	Tissue conditioning, maxillary	\$100	\$100		
D5851	Tissue conditioning, mandibular	\$100	\$100		
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered					
D6000-D6199 VIII. IMPLANT SERVICES - Not Covered					
D6200-D6999 IX. PROSTHODONTICS, fixed					
<i>- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge)</i>					
D6210	Pontic - cast high noble metal	\$350	\$350		
D6211	Pontic - cast predominantly base metal	\$350	\$350		
D6212	Pontic - cast noble metal	\$350	\$350		
D6214	Pontic - titanium	\$350	Not a benefit		
D6240	Pontic - porcelain fused to high noble metal	\$300	\$350		
D6241	Pontic - porcelain fused to predominantly base metal	\$350	\$350		
D6242	Pontic - porcelain fused to noble metal	\$350	\$350		

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D6245	Pontic - porcelain/ceramic	Not a benefit	\$350		
D6250	Pontic - resin with high noble metal	Not a benefit	\$320		
D6251	Pontic - resin with predominantly base metal	Not a benefit	\$300		
D6252	Pontic - resin with noble metal	Not a	\$320		
D6600	Inlay - porcelain/ceramic, two surfaces	Not a benefit	\$335		
D6601	Inlay - porcelain/ceramic, three or more surfaces	Not a benefit	\$360		
D6602	Inlay - cast high noble metal, two surfaces	Not a benefit	\$270		
D6603	Inlay - cast high noble metal, three or more surfaces	Not a benefit	\$280		
D6604	Inlay - cast predominantly base metal, two surfaces	Not a benefit	\$220		
D6605	Inlay - cast predominantly base metal, three or more surfaces	Not a benefit	\$230		
D6606	Inlay - cast noble metal, two surfaces	Not a benefit	\$250		
D6607	Inlay - cast noble metal, three or more surfaces	Not a benefit	\$260		
D6608	Onlay - porcelain/ceramic, two surfaces	Not a benefit	\$395		
D6609	Onlay - porcelain/ceramic, three or more surfaces	Not a benefit	\$425		
D6610	Onlay - cast high noble metal, two surfaces	\$350	\$350		
D6611	Onlay - cast high noble metal, three or more surfaces	\$350	\$350		
D6612	Onlay - cast predominantly base metal, two surfaces	\$350	\$350		
D6613	Onlay - cast predominantly base metal, three or more surfaces	\$350	\$350		
D6614	Onlay - cast noble metal, two surfaces	\$350	\$350		
D6615	Onlay - cast noble metal, three or more surfaces	\$350	\$350		
D6720	Crown - resin with high noble metal	Not a benefit	\$350		
D6721	Crown - resin with predominantly base metal	Not a benefit	\$350		
D6722	Crown - resin with noble metal	Not a	\$350		
D6740	Crown - porcelain/ceramic	\$350	\$350		
D6750	Crown - porcelain fused to high noble metal	\$350	\$350		
D6751	Crown - porcelain fused to predominantly base metal	\$300	\$300		
D6752	Crown - porcelain fused to noble metal	\$350	\$350		
D6780	Crown - 3/4 cast high noble metal	\$350	\$350		
D6781	Crown - 3/4 cast predominantly base metal	\$350	\$350		

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D6782	Crown - 3/4 cast noble metal	\$350	\$350		
D6783	Crown - 3/4 porcelain/ceramic	\$350	\$350		
D6790	Crown - full cast high noble metal	\$350	\$350		
D6791	Crown - full cast predominantly base metal	\$350	\$350		
D6792	Crown - full cast noble metal	\$350	\$350		
D6794	Crown - titanium	\$350	Not a benefit		
D6930	Recement fixed partial denture	\$80	\$80		
D6940	Stress breaker	\$138	\$78		
D6975	Coping	Not a benefit	\$220		
D6980	Fixed partial denture repair necessitated by restorative material failure	\$200	\$200		

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative evaluations and treatment under a local anesthetic. Postoperative services include exams, suture removal and treatment of complications.

D7111	Extraction, coronal remnants - deciduous tooth	Not a benefit	\$25		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$65	\$65		
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$165	\$80		
D7220	Removal of impacted tooth - soft tissue	\$225	\$90		
D7230	Removal of impacted tooth - partially bony	\$180	\$180		
D7240	Removal of impacted tooth - completely bony	\$160	\$160		
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$300	\$300		
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$165	\$165		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Not a benefit	\$25		
D7280	Surgical access of an unerupted tooth	Not a benefit	\$85		
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Not a benefit	\$80		
D7283	Placement of device to facilitate eruption of impacted tooth	Not a benefit	No Cost		
D7285	Biopsy of oral tissue - hard (bone, tooth)	\$197	Not a benefit		

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D7286	Biopsy of oral tissue - soft	\$180	\$180		
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$160	\$160		
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$130	\$130		
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$180	\$180		
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$160	\$160		
D7410	Excision of benign lesion up to 1.25 cm	\$175	Not a benefit		
D7411	Excision of benign lesion greater than 1.25 cm	\$225	Not a benefit		
D7412	Excision of benign lesion, complicated	\$325	Not a benefit		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$160	\$160		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$300	\$300		
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$141	Not a benefit		
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$228	Not a benefit		
D7471	Removal of lateral exostosis (maxilla or mandible)	\$350	\$350		
D7472	Removal of torus palatinus	\$350	\$350		
D7473	Removal of torus mandibularis	\$350	\$350		
D7510	Incision and drainage of abscess - intraoral soft tissue	\$110	\$110		
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$170	Not a benefit		
D7520	Incision and drainage of abscess - extraoral soft tissue	\$180	Not a benefit		
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$225	Not a benefit		
D7910	Suture of recent small wounds up to 5 cm	\$150	Not a benefit		
D7911	Complicated suture - up to 5 cm	\$205	Not a benefit		

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D7912	Complicated suture - greater than 5 cm	\$300	Not a benefit		
D7960	Frenulectomy - also known as frenectomy or frenotomy -	\$250	\$250		
D7963	Frenuloplasty	\$200	Not a benefit		
D7970	Excision of hyperplastic tissue - per arch	Not a benefit	\$50		
D7971	Excision of pericoronal gingiva	Not a benefit	\$30		

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

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

- *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 orthodontist or dental office who received the comprehensive case fee. A separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*

- *Refer to Schedule B for additional information on Medically Necessary Orthodontics.*

Pre-treatment Records after Approved Referral for Thumb Sucking or Tongue Thrust Appliance:

D0220	Intraoral - periapical first radiographic image	No Cost	Not a benefit	<i>Anterior only of the affected arch; for orthodontic records only</i>	
D0230	Intraoral - periapical each additional radiographic image	No Cost	Not a benefit	<i>Anterior only of the affected arch; for orthodontic records only</i>	

Pre-treatment Records after Approved Referral for Evaluation of Handicapping Malocclusion:

D0350	Oral/facial photographic images obtained intraorally or extraorally	No Cost	Not a benefit	<i>Limited to images with and as a part of a covered pre-orthodontic treatment visit</i>	
D0470	Diagnostic casts	No Cost	Not a benefit		

Pre-treatment Records with Plan Prior Approval for Comprehensive Orthodontics:

D0210	Intraoral - complete series of radiographic images	No Cost	Not a benefit	<i>For covered orthodontic records only</i>	
D0322	Tomographic survey	\$100	Not a benefit	<i>Only with documentation of medical necessity for cleft palates or craniofacial anomalies</i>	
D0340	Cephalometric radiographic image	\$35	Not a benefit		

Post-treatment Records after Completion of Covered Comprehensive Orthodontics:

D0210	Intraoral - complete series of radiographic images	No Cost	Not a benefit	<i>For covered orthodontic records only</i>	
D0340	Cephalometric radiographic image	\$35	Not a benefit	<i>Only with documentation of medical necessity for cleft palates or craniofacial anomalies</i>	

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D0350	Oral/facial photographic images obtained intraorally or extraorally	No Cost	Not a benefit	Limited to images with and as a part of a covered orthodontic treatment visit	
D0470	Diagnostic casts	No Cost	Not a benefit		
D8050	Interceptive orthodontic treatment of the primary dentition	\$350	Not a benefit	Limited to Enrollee with a qualifying handicapping malocclusion and a cleft palate or craniofacial anomaly	
D8060	Interceptive orthodontic treatment of the transitional dentition	\$350	Not a benefit	Limited to Enrollee with a qualifying handicapping malocclusion and a cleft palate or craniofacial anomaly	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$350	Not a benefit		
D8210	Removable appliance therapy	\$300	Not a benefit		
D8220	Fixed appliance therapy	\$350	Not a benefit		
D8660	Pre-orthodontic treatment visit	\$75	Not a benefit		
D8670	Periodic orthodontic treatment visit (as part of contract)	\$75	Not a benefit	Included in the orthodontic case fee	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$250	Not a benefit	Removable retainer(s); included in the orthodontic case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office who was paid for banding	
D8691	Repair of orthodontic appliance	\$105	Not a benefit		
D8692	Replacement of lost or broken retainer	\$150	Not a benefit		
D8693	Rebonding or recementing of fixed retainers	\$68	Not a benefit		
D8694	Repair of fixed retainers, includes reattachment	\$68	Not a benefit		
D8000-D8999 XI. ORTHODONTICS – for Adult Enrollees (age 19 and up)					
<p>- Including covered dependent adult children</p> <p>- The Enrollee must continue to be eligible during active treatment. The listed Copayment for each phase of orthodontic treatment (limited or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed \$125.00, may apply.</p> <p>- The Retention Copayment includes adjustments and/or office visits up to 24 months.</p>					
Pre and post orthodontic records include:					
The benefit for pre-treatment records and diagnostic services includes:		Not a benefit	\$250		

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D0210	Intraoral - complete series of radiographic images	Not a benefit	Included		
D0322	Tomographic survey	Not a benefit	Included		
D0330	Panoramic radiographic image	Not a benefit	Included		
D0340	Cephalometric radiographic image	Not a benefit	Included		
D0350	Oral/facial photographic images obtained intraorally or extraorally	Not a benefit	Included		
D0470	Diagnostic casts	Not a benefit	Included		
<i>The benefit for post-treatment records includes:</i>		Not a benefit	\$70		
D0210	Intraoral - complete series of radiographic images	Not a benefit	Included		
D0470	Diagnostic casts	Not a benefit	Included		
D8040	Limited orthodontic treatment of the adult dentition	Not a benefit	\$1950		
D8090	Comprehensive orthodontic treatment of the adult dentition	Not a benefit	\$3250		
D8660	Pre-orthodontic treatment visit	Not a benefit	\$51		
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Not a benefit	\$450		
D8999	Unspecified orthodontic procedure, by report	Not a benefit	\$250		<i>Includes treatment planning session</i>
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES					
D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$55	\$55		
D9211	Regional block anesthesia	Not a benefit	No Cost		
D9212	Trigeminal division block anesthesia	Not a benefit	No Cost		
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$35	\$35		
D9220	Deep sedation/general anesthesia - first 30 minutes	\$225	\$225	<i>Covered only when given by a Contract Dentist for covered oral surgery</i>	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	\$95	\$95	<i>Covered only when given by a Contract Dentist for covered oral surgery</i>	
D9230	Inhalation of nitrous oxide / anxiolysis, analgesia	\$45	Not a benefit	<i>Per 30 minute increment (where available)</i>	
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	\$225	\$225	<i>Covered only when given by a Contract Dentist for covered oral surgery</i>	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	\$95	\$95	<i>Covered only when given by a Contract Dentist for covered oral surgery</i>	

Code	Description	Pediatric Pays	Adult Pays	Clarification/ Limitations for Pediatric Enrollees	Clarifications/ Limitations for Adult Enrollees
D9248	Non-intravenous conscious sedation	\$120	Not a Benefit	<i>(Where available)</i>	
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$75	\$75		
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost	No Cost		
D9440	Office visit - after regularly scheduled hours	\$75	\$75		
D9450	Case presentation, detailed and extensive treatment planning	Not a benefit	\$25		
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	\$90	Not a benefit		
D9940	Occlusal guard, by report	Not a benefit	\$175		<i>Limited to 1 in 3 years</i>
D9950	Occlusion analysis - mounted case	Not a benefit	\$160		
D9951	Occlusal adjustment - limited	Not a benefit	\$25		
D9952	Occlusal adjustment - complete	Not a benefit	\$95		
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	Not a benefit	\$125		<i>Limited to one bleaching tray and gel for two weeks of self treatment</i>
D9999	Unspecified adjunctive procedure, by report	\$50	\$50	<i>Includes failed appointment without 24 hour notice</i>	<i>Includes failed appointment without 24 hour notice</i>

Endnotes:

Base metal is the benefit. If noble or high noble metal (precious) is used for a crown, bridge, indirectly fabricated post and core, inlay or onlay, the Enrollee will be charged the additional laboratory cost of the noble or high noble metal. If covered, an additional laboratory charge also applies to a titanium crown.

Porcelain/ceramic crown, pontic and fixed bridge retainer on molars is considered a material upgrade with a maximum additional charge to the Enrollee of \$150 per unit.

For a covered porcelain-fused-to-metal crown, a porcelain margin is considered a material upgrade with a maximum additional charge to the Enrollee of \$75 per unit.

Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed \$325 in addition to the listed Copayment. Refer to *Schedule B for Limitations and Exclusions* for additional information.

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

Procedures not listed above or noted as "not a benefit" are not covered, however, may be available at the Contract Dentist's "filed fees".

"Filed fees" mean the Contract Dentist's fees on file with the plan. Questions regarding these fees should be directed to the Customer Service department at 800-471-7583.

Optional is defined as any alternative procedure presented by the DeltaCare USA dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee and is subject to the limitations and exclusions of the plan. The applicable charge to the Enrollee is the difference between the DeltaCare USA dentist's usual and customary fee for the Optional procedure and the usual and customary fee for the covered procedure, plus any applicable Co-payment for the covered procedure.

SCHEDULE B
Limitations and Exclusions of Benefits
DeltaCare® USA
Family Dental HMO
for Small Businesses

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

Limitations of Benefits for Adult Enrollees

1. The frequency of certain Benefits is limited. Frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*. Additional clarifications on restorations and prosthodontics are as follows:
 - a. Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge/restoration to be 5+ years old, unless the bridge/restoration is no longer functional and cannot be made functional by repair or adjustment.
 - b. Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.
 - c. Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional \$125.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed \$325.00 in addition to the listed Copayment. Contact the Customer Service department at 800-471-7583 if you have questions regarding the additional fee or name brand services.
5. Benefits for a soft tissue management program are limited to those parts which are listed covered services listed on *Schedule A, Description of Benefits and Copayments*.
6. 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 or office where the denture was originally delivered.
7. Porcelain/ceramic crown, pontic and fixed bridge retainer on molars is considered a material upgrade with a maximum additional charge to the Enrollee of \$150 per unit.
8. For a covered porcelain-fused-to-metal crown, a porcelain margin is considered a material upgrade with a maximum additional charge to the Enrollee of \$75 per unit.
9. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any

reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.

Exception to extend covered orthodontics benefits to a cancelled or terminated Contract is as follows:

- a. For 60 days after the date coverage terminates if the Contract Orthodontist has agreed to or is receiving monthly payments; or
 - b. Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Contract Orthodontist has agreed to accept or is receiving payments on a quarterly basis.
10. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA plan. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. The plan is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits for Adult Enrollees

1. Any procedure that is not specifically listed as a covered Benefit under *Schedule A, Description of Benefits and Copayments*.
2. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (external bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
4. Lost, stolen or broken appliances including, but not limited to, full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges) and orthodontic appliances.
5. Procedures, appliances or restoration if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), with the exception of procedures D9951 and D9952 as shown on *Schedule A, Description of Benefits and Copayments*.
6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
8. Consultations or other diagnostic services for non-covered benefits.
9. Dental services received from any dental facility other than the assigned Contract Dentist or an authorized dental specialist (oral surgeon, endodontist, periodontist, pediatric dentist or Contract Orthodontist) except for *Emergency Services* as described in the Contract.
10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
11. Prescription and over-the-counter drugs.

12. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
 13. Changes in orthodontic treatment necessitated by accident of any kind.
 14. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedure D9940 (occlusal guard, per report).
 15. Composite or ceramic brackets, lingual adaptation of orthodontic bands, Invisalign and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
 16. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
 17. Any part of a preventive or soft tissue management program which is not a listed covered service on *Schedule A, Description of Benefits and Copayment*.
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Limitations and Exclusions of Benefits for Pediatric Enrollees (Under age 19)

Limitations of Benefits for Pediatric Enrollees

1. Diagnostic and Preventive Benefits are limited as follows:
 - a) Bitewing radiographic images in conjunction with periodic examinations are limited to one (1) series of four (4) films in any six (6) consecutive month period. Isolated bitewing or periapical radiograph images are allowed on an emergency or episodic basis.
 - b) Full mouth radiographic images in conjunction with periodic examinations are limited to once every twenty-four (24) consecutive months.
 - c) Panoramic radiographic images are limited to once every twenty-four (24) consecutive months.
 - d) Caries risk assessment and documentation is limited to Enrollees age 3 to 18; limited to one (1) per thirty-six (36)-month period when performed by same Contract Dentist or office.
 - e) Prophylaxis services (D1110, D1120) (cleanings) are limited to two (2) in a twelve (12)-month period.
 - f) Topical applications of fluoride are limited to two (2) in a twelve (12) month period.
 - g) Dental sealant treatments are limited to permanent first and second molars only. The teeth must be caries free with no restorations on the mesial, distal or occlusal surfaces.
2. Restoration Benefits are limited to the following:
 - a) For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations, any other restoration such as a crown or jacket is considered optional.
 - b) Composite resin or acrylic restorations in posterior teeth are optional.
 - c) Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.
3. Endodontic Benefits are limited as follows:

Root canal therapy, including culture canal, is limited as follows:

- a) Re-treatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
- b) Removal or re-treatment of silver points, overfills, underfills, incomplete fills or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

4. Periodontal Benefits are limited as follows:

- a) Periodontal scaling and root planing and subgingival curettage are limited to five (5) quadrant treatments in any twelve (12) consecutive months.

5. Restorative and fixed prosthodontic onlay, crown and pontic. Benefits are limited as follows:

The crown benefit is limited as follows:

- a) Replacement of each unit is limited to once every thirty-six (36) consecutive months, except when the crown is no longer functional as determined by the dental plan.
- b) Only acrylic crowns and stainless steel crowns are a benefit for children under twelve (12) years of age. If other types of crowns are chosen as an optional benefit for children under twelve (12) years of age, the covered dental benefit level will be that of an acrylic crown.
- c) Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- d) Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.
- e) Porcelain/ceramic crowns and pontics on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$150 per unit. For a covered porcelain-fused-to-metal crown or pontic, a porcelain margin is considered a material upgrade with a maximum additional charge to the Enrollee of \$75 per unit.

The fixed bridge benefit is limited as follows:

- a) Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
- b) A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person sixteen (16) years of age or older and the patient's oral health and general dental condition permits. For children under the age of sixteen (16), it is considered optional dental treatment. If performed on an Enrollee under the age of sixteen (16), the Enrollee must pay the difference in cost between the fixed bridge and a space maintainer.
- c) Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- d) Fixed bridges are optional when provided in connection with a partial denture on the same arch.
- e) Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.
- f) The plan allows up to five (5) units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.
- g) Porcelain/ceramic fixed bridge retainers on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$150 per unit.

6. Removable Prosthetic Benefits are limited as follows:

- a) Partial dentures will not be replaced within thirty-six (36) consecutive months unless:
 - 1) It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible; or
 - 2) The denture is unsatisfactory and cannot be made satisfactory.

- b) The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the Enrollee and the Contract Dentist, and is not necessary to satisfactorily restore an arch, the Enrollee will be responsible for all additional charges.
 - c) A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
 - d) Full upper and/or lower dentures are not to be replaced within thirty-six (36) consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by relines or repair.
 - e) The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.
 - f) Office or laboratory relines or rebases are limited to one (1) per arch in any twelve (12) consecutive months.
 - g) Tissue conditioning is limited to two (2) per denture.
 - h) Implants are considered an optional benefit.
 - i) Stayplates are a benefit only when used as anterior space maintainers for children.
7. Oral surgery limitation:
- a) The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.
8. Other Benefits are limited as follows:
- a) Oral sedatives are limited to those dispensed in a dental office by a practitioner acting within the scope of their licensure.
 - b) Nitrous oxide is limited to when it is dispensed in a dental office by a practitioner acting within the scope of their licensure.
 - c) A broken appointment charge will be applied in a fair and reasonable manner and will not apply in exigent circumstances where advance notice of cancellation was not reasonably possible.
9. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan benefits of a high quality laboratory processed crown/ that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed \$325.00 in addition to the listed Copayment. Contact the Customer Service department at 800-471-7583 if you have questions regarding the additional fee or name brand services.

Exclusions of Benefits for Pediatric Enrollees

The following dental services are excluded under the plan:

1. Services which, in the opinion of the Contract Dentist, are not necessary to the Enrollee's dental health.
2. Procedures, appliances or restorations to correct congenital or developmental malformations are not covered Benefits unless specifically listed under *Schedule A, Description of Benefits and Copayments*.
3. Cosmetic dental care.
4. General anesthesia or intravenous/conscious sedation, unless specifically listed as a benefit or is given by a DeltaCare USA Contract Dentist for covered oral surgery.
5. Experimental or investigational procedures.

6. Dental conditions arising out of and due to an Enrollee's employment for which Worker's Compensation or an Employer's Liability Law is payable. The participating dental plan shall provide the services at the time of need and the Enrollee shall cooperate to ensure that the participating dental plan is reimbursed for such Benefits.
7. Services which were provided without cost to the Enrollee by the State government or an agency thereof, or any municipality, county or other subdivisions.
8. All related fees for admission, use, or stays in a hospital, outpatient surgery center, extended care facility, or other similar care facility.
9. Major surgery for fractures and dislocations.
10. Loss or theft of dentures, fixed partial dentures (bridgework) or other appliances.
11. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Enrollee became eligible for such services.
12. Any service that is not specifically listed as a covered Benefit under *Schedule A, Description of Benefits and Copayments*.
13. Malignancies.
14. Dispensing of drugs not normally supplied in a dental office.
15. Additional treatment costs incurred because a dental procedure is unable to be performed in the Contract Dentist's office due to the general health and physical limitations of the Enrollee.
16. The cost of precious metals used in any form of dental Benefits.
17. The surgical removal of implants.
18. Services of a pedodontist/pediatric dentist for an Enrollee, except when the Enrollee is unable to be treated by his or her primary care Contract Dentist, or treatment by a pedodontist/pediatric dentist is medically necessary.
19. Services which are eligible for reimbursement by insurance or covered under any other insurance, health care service plan or dental plan. The participating dental plan shall provide the services at the time of need and the Enrollee shall cooperate to ensure that the participating dental plan is reimbursed for such Benefits.
20. Consultations or other diagnostic services for non-covered benefits.

Medically Necessary Orthodontic for Pediatric Enrollees

1. Coverage for comprehensive orthodontic treatment 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. Comprehensive orthodontic treatment:
 - a) is limited to Enrollees who are between 13 to 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.
2. 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.
3. The benefit for a pre-orthodontic treatment visit (D8660) includes needed oral/facial photographic images (D0350). Neither the Enrollee nor the plan may be charged for D0350 in conjunction with a pre-

orthodontic treatment visit.

4. The number of covered periodic orthodontic treatment 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.
5. Orthodontic retention (D8680) is a separate benefit after the completion of covered comprehensive orthodontic treatment which:
 - a) Includes removal of appliances and the construction and place of retainer(s); 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.
6. Copayment is payable to the Contract Orthodontist who initiates banding in a course of prior authorized orthodontic treatment. 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.
7. 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, 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. For 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 usual 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.

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. THIS CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PLAN BENEFITS AND LIMITATIONS.

(A) Deductibles	None																																												
(B) Lifetime Maximums	None																																												
(C) Annual Out-of-Pocket Maximum	<table> <tr> <td>Individual</td> <td>\$350.00</td> </tr> <tr> <td>Multiple Child</td> <td>\$700.00</td> </tr> </table>	Individual	\$350.00	Multiple Child	\$700.00																																								
Individual	\$350.00																																												
Multiple Child	\$700.00																																												
(D) Professional Services	<p>An Enrollee may be required to pay a Copayment amount for each procedure as shown in the Schedule of Benefits and Copayments, subject to the limitations and exclusions of the Program.</p> <p>Copayments range by category of service. Examples are as follows:</p> <table> <tr> <td>Diagnostic Services</td> <td>No Cost</td> <td></td> <td></td> </tr> <tr> <td>Preventive Services</td> <td>No Cost</td> <td></td> <td></td> </tr> <tr> <td>Restorative Services</td> <td>No Cost</td> <td>-</td> <td>\$ 370.00</td> </tr> <tr> <td>Endodontic Services</td> <td>\$ 40.00</td> <td>-</td> <td>\$ 350.00</td> </tr> <tr> <td>Periodontic Services</td> <td>No Cost</td> <td>-</td> <td>\$ 350.00</td> </tr> <tr> <td>Prosthodontic Services, Removable</td> <td>\$ 45.00</td> <td>-</td> <td>\$ 350.00</td> </tr> <tr> <td>Prosthodontic Services, Fixed</td> <td>\$ 78.00</td> <td>-</td> <td>\$ 425.00</td> </tr> <tr> <td>Oral and Maxillofacial Surgery</td> <td>No Cost</td> <td>-</td> <td>\$ 350.00</td> </tr> <tr> <td>Orthodontic Services (medically necessary only-Pediatric)</td> <td>No Cost</td> <td>-</td> <td>\$ 350.00</td> </tr> <tr> <td>(adult)</td> <td>No Cost</td> <td>-</td> <td>\$ 350.00</td> </tr> <tr> <td>Adjunctive General Services</td> <td>No Cost</td> <td>-</td> <td>\$ 225.00</td> </tr> </table> <p>NOTE: Some services may not be covered. Certain services may be covered only if provided by specified Dentists, or may be subject to an additional charge.</p> <p>Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to two in a 12 month period; Replacement of a crown is limited to once every thirty-six (36) consecutive months for Pediatric Enrollees and once every sixty (60) consecutive months for Adult Enrollees.</p>	Diagnostic Services	No Cost			Preventive Services	No Cost			Restorative Services	No Cost	-	\$ 370.00	Endodontic Services	\$ 40.00	-	\$ 350.00	Periodontic Services	No Cost	-	\$ 350.00	Prosthodontic Services, Removable	\$ 45.00	-	\$ 350.00	Prosthodontic Services, Fixed	\$ 78.00	-	\$ 425.00	Oral and Maxillofacial Surgery	No Cost	-	\$ 350.00	Orthodontic Services (medically necessary only-Pediatric)	No Cost	-	\$ 350.00	(adult)	No Cost	-	\$ 350.00	Adjunctive General Services	No Cost	-	\$ 225.00
Diagnostic Services	No Cost																																												
Preventive Services	No Cost																																												
Restorative Services	No Cost	-	\$ 370.00																																										
Endodontic Services	\$ 40.00	-	\$ 350.00																																										
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Orthodontic Services (medically necessary only-Pediatric)	No Cost	-	\$ 350.00																																										
(adult)	No Cost	-	\$ 350.00																																										
Adjunctive General Services	No Cost	-	\$ 225.00																																										
(E) Outpatient Services	Not Covered																																												
(F) Hospitalization Services	Not Covered																																												
(G) Emergency Dental Coverage	Benefits for Emergency Services by an Out-of-Network Dentist are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.																																												
(H) Ambulance Services	Not Covered																																												
(I) Prescription Drug Services	Not Covered																																												
(J) Durable Medical Equipment	Not Covered																																												
(K) Mental Health Services	Not Covered																																												
(L) Chemical Dependency Services	Not Covered																																												
(M) Home Health Services	Not Covered																																												
(N) Other	Not Covered																																												

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

HIPAA Notice of Privacy Practices

Confidentiality of your health care 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.

This notice is required by law to inform you of how Delta Dental and its affiliates ("Delta Dental") protect the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as individually identifiable information regarding a patient's health care history, mental or physical condition or treatment. 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. Delta Dental receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We follow the privacy practices described in this notice and federal and state privacy requirements that apply to our administration of your benefits. Delta Dental reserves the right to change our privacy practice effective for all PHI maintained. We will update this notice if there are material changes and redistribute it to you within 60 days of the change to our practices. We will also promptly post a revised notice on our website. A copy may be requested anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Delta Dental program and will be informed on how to obtain a copy at least every three years.

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 about yourself, or for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. 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 also disclose PHI to third party affiliates that perform services for Delta Dental to administer your benefits. As permitted by law, we may disclose PHI to third-party affiliates that perform services for Delta Dental to administer your benefits, and who have signed a contract agreeing to

protect the confidentiality of your PHI, and have implemented privacy policies and procedures that comply with applicable federal and state law.

Some examples of disclosure and use for treatment, payment or operations 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. Some other examples are:

- Uses and/or disclosures of PHI in facilitating treatment. *For example, Delta Dental may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment. *For example, Delta Dental may use and disclose your PHI to bill you or your plan sponsor.*
- Uses and/or disclosures of PHI for health care operations. *For example, Delta Dental may use and disclose your PHI to review the quality of care provided by our network of providers.*

Other 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 law, and when otherwise required by law. Delta Dental 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 Delta Dental makes with your authorization

Delta Dental will not use or disclose your PHI without your prior written authorization unless permitted by law. You can later revoke that authorization, in writing, to stop the future use and disclosure. The authorization will be obtained from you by Delta Dental or by a person requesting your PHI from Delta Dental.

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 contacting Delta Dental at the address at the bottom of this notice. You must include (1) your name, address, telephone number and identification number, and (2) the PHI you are requesting. Delta Dental may charge a reasonable fee for providing you copies of your PHI. Delta Dental will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or x-rays, is returned by Delta Dental to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Delta Dental does 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. Please contact Delta Dental as noted below if you have questions about access to your PHI.

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. If we accept your request, we will put our understanding in writing.

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. 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 dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have the right to opt-out of Delta Dental using your PHI for fundraising and marketing.

Delta Dental does not use your PHI for either marketing or fundraising purposes. If we change our practice, we must give you the opportunity to opt-out.

You have the right to request or receive confidential communications from us by alternative means or at a different address.

Alternate or confidential communication is available if disclosure of your PHI to the address on file could endanger you. You may be required to provide us with a statement of possible danger, as well as specify a different address or another method of contact. Please make this request in writing to the address noted at the end of this notice.

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. Please contact us at the number at the end of this notice if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by e-mail.

A copy of this notice is posted on the Delta Dental website. You may also request an email copy or paper copy of this notice by calling our Customer Service number listed at the bottom of this notice.

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

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

Complaints

You may file a complaint to Delta Dental and/or to the U. S. Secretary of Health and Human Services if you believe Delta Dental has violated your privacy rights. Complaints to Delta Dental

may be filed by notifying the contact below. We will not retaliate against you for filing a complaint.

Contacts

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

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330

This notice is effective on and after July 1, 2013.

Language Assistance

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. For free help, please call Delta Dental at 800-765-6003. You may also be able to receive this document in Spanish or Chinese.

IMPORTANTE: ¿Puede leer este documento? Si no, podemos ayudarle. Para obtener ayuda gratis, llame a Delta Dental at 800-765-6003. También puede recibir este documento en español o chino.

重要通知：您能讀這份文件嗎？如有問題，我們可請他人協助您。如需免費協助，請電 Delta Dental 800-765-6003。您也能取得這份文件的西班牙文或中文譯本。

Delta Dental and its Affiliates

Delta Dental of California offers and administers fee-for-service dental programs for groups headquartered in the state of California.

Delta Dental of New York offers and administers fee-for-service programs in New York.

Delta Dental of Pennsylvania and its affiliates offer and administer fee for-service dental programs in Delaware, Maryland, Pennsylvania, West Virginia and the District of Columbia. Delta Dental of Pennsylvania's affiliates are Delta Dental of Delaware; Delta Dental of the District of Columbia and Delta Dental of West Virginia.

Delta Dental Insurance Company offers and administers fee-for-service dental programs to groups headquartered or located in Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas and Utah and vision programs to groups headquartered in West Virginia.

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, ME, MI, NC, NH, OK, OR, RI, SC, SD, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN and 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; VA — Delta Dental of Virginia. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products. Dentegra Insurance Company.

Summary of Changes to this notice (effective July 1, 2013):

- Updated contact information (mailing address and phone number)
- Updated Delta Dental's duty to notify affected individuals if a breach of their unsecured PHI occurs

- Clarified that Delta Dental does not and will not sell your information without your express written authorization
- Clarified several instances where the law requires individual authorization to use and disclose information (e.g., fundraising and marketing as noted above)