DeltaCare® USA

A Prepaid Dental Plan for

UNIVERSITY OF CALIFORNIA

Employees, Retirees, and Their Dependents

Evidence of Coverage and Disclosure Statement
January 1, 2025

Underwritten by:

Delta Dental of California
18000 Studebaker Road, Suite 530
Cerritos, CA 90703

Administered by:

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

https://www1.deltadentalins.com/group-sites/uc.html

EVIDENCE OF COVERAGE
DISCLOSURE FORM
OF THE DENTAL PROGRAM
FOR ELIGIBLE EMPLOYEES AND RETIREES OF
THE UNIVERSITY OF CALIFORNIA

This booklet is a Combined Evidence of Coverage and Disclosure Form ("EOC") for your DeltaCare USA Dental HMO Program ("Program") provided by Delta Dental of California ("Delta Dental"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") #72039 issued by Delta Dental.

Delta Dental of California
18000 Studebaker Road, Suite 530
Cerritos, CA 90703
800-422-4234

Or contact us on the internet at:
https://www1.deltadentalins.com/group-sites/uc.html

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

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

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

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

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a Contract Dentist may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Customer Service at 800-422-4234. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

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

Table of Contents

Eligibility
The University establishes its own dental plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations and any corresponding Administrative Supplements.

Employees
Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the "Group Insurance Eligibility Fact Sheet for Employees and Eligible Family Members." A copy of this fact sheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

Retirees
Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the "Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members." A copy of this fact sheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

Enrollment
Employees
Information pertaining to enrollment can be found in the "Group Insurance Eligibility Fact Sheet for Employees and Eligible Family Members." A copy of this fact sheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu).

Retirees
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Definitions
Certain terms used throughout this document begin with capital letters. When these terms are capitalized, use the following definitions to understand their meanings as they pertain to Your benefits and how the dental Plan works.

ADDITIONAL FEE(S) means the difference in cost of the covered Benefit and the Usual Fee for Optional treatment.

ADMINISTRATOR means a third party entity designated by Delta Dental to perform administrative functions, including, but not limited to, the collection of premium and eligibility.

BENEFITS mean those dental services which are described in this booklet.

BILLED FOR THE CHARGE means a bill that provides, at a minimum, an accurate itemization of the premium amounts due, the due dates(s), and the period of time covered by the premium(s).

CLIENT means The University of California contracting to obtain Benefits for Eligible Employees.

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

CONTRACT ORTHODONTIST means a Dentist who specializes in orthodontics and has agreed to provide Benefits to Enrollees under this Program.

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

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

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

ELIGIBLE DEPENDENT means any dependent (as defined in the Eligibility Section) of an Eligible Employee who is eligible for Benefits as described in this booklet.

ELIGIBLE EMPLOYEE means any employee (as defined in the Eligibility Section) or group member who is eligible for Benefits as described in this booklet.

EMERGENCY DENTAL CONDITION means dental symptoms and/or pain that are so severe that, without immediate attention by a Dentist, it could reasonably result in any of the following:

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

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

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

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

MEDICALLY NECESSARY GENERAL ANESTHESIA means physical limitations or health conditions that prohibit treatment being rendered under local anesthesia. Such limitations or conditions must be verified in writing by a physician.

NOTICE OF END OF COVERAGE: the notice sent to by US notifying the recipient that the Your coverage has been cancelled.

NOTICE OF START OF GRACE PERIOD: the notice sent by Us that the plan will be terminated unless the premium amount due is received no later than the last day of the Grace Period.

OUT-OF-NETWORK means treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits under this Program.

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

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

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

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

TREATMENT PLAN means the procedures developed by your Contract Dentist to provide dental care for a particular condition.

URGENT DENTAL SERVICES means medically necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

USUAL FEE means the fee that an individual Dentist most frequently charges for a given service.

WE, US or OUR means Delta Dental of California or the Administrator as appropriate.

General Information

Delta Dental is founded on the principle of delivering quality dental care and preventing dental problems before they start. Dental services are provided solely by your selected DeltaCare USA Contract Dentist. If any services are provided by a non-DeltaCare USA Contract Dentist or specialist, you will be obligated to pay for such services.

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

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

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at **800-422-4234**. If you cannot keep your appointment, notify the Contract Dentist's office at least 24 hours in advance, or you will be charged for a broken appointment.

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

To receive Benefits, other than for out-of-area emergency dental care, service must be rendered by: your assigned DeltaCare USA Contract Dentist; a dental hygienist under his/her supervision; or a specialist to whom your DeltaCare USA Contract Dentist has referred you, and whose treatment has been preauthorized in writing by Delta Dental.

If you have any questions about a prior authorization, please call Delta Dental at the numbers listed on the back page of this booklet.

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

Continuity of Care

Current Members:

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

New Members:

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

Special Needs

If an Enrollee believes he or she has a Special Health Care Need, the Enrollee should contact Delta Dental's Customer Service department at **800-422-4234**. Delta Dental will confirm that a Special Health Care Need exists, and what arrangements can be made to assist the Enrollee in obtaining such Benefits. Delta Dental shall not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Dentist treating persons with Special Health Care Needs.

Facility Accessibility

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

Benefits, Limitations and Exclusions

This Plan provides Benefits and any applicable Copayments, deductibles, annual maximums and waiting periods as shown in the attached Schedules. Only services, supplies or procedures listed in the Schedules and deemed appropriate by Your Contract Dentist are covered under this Plan. Contract Dentists may provide services directly or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

In order to keep Your Plan affordable, this Plan includes certain cost-sharing features. First, not all dental services or procedures may be included under Your Plan. If the procedure is not listed in the *Schedules*, it is not covered. You will be responsible to pay the Dentist the full charge for any service not included in Your Plan. Certain procedures require You to pay a Copayment. Copayments are listed in the *Schedules* and must be paid directly to the treating Dentist. Any charges for broken appointments and visits after normal visiting hours, if covered, are also listed in the *Schedules*.

Emergency Dental Services

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

After Emergency Dental Services are provided, further non-emergency treatment is usually needed. Non-emergency treatment must be obtained at the Enrollee's assigned Contract Dentist's facility.

The Enrollee is responsible for any Copayment(s) for Emergency Dental Services received. Non-covered procedures will be the Enrollee's financial responsibility and will not be paid by this plan.

Urgent Dental Services Inside the Service Area

An Urgent Dental Service requires prompt dental attention but is not an Emergency Dental Condition. If an Enrollee thinks that he or she may need Urgent Dental Services, the Enrollee can call his or her Contract Dentist.

Out-of-Area Urgent Care

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

- The Enrollee receives the Urgent Dental Services from Out-of-Network Dentists while temporarily outside of the Delta Dental Service Area.
- A reasonable person would have believed that the Enrollee's health would seriously deteriorate if he or she delayed treatment until they returned to the Delta Dental Service Area.

You do not need prior authorization for out-of-area Urgent Dental Services. The out-of-area Urgent Dental Services You receive from Out-of-Network Dentists are covered if the Benefits would have been covered if You had received the Urgent Dental Services from Contract Dentists.

We do not cover follow-up care from Out-of-Network Dentists after the Enrollee no longer needs Urgent Dental Services. To obtain follow-up care from a Contract Dentist, the Enrollee can call his or her Contract Dentist. The Enrollee is responsible for any Copayment(s) for Urgent Dental Services received.

Specialist Services

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

If you require Specialist Services and there is no Contract Specialist to provide these services within 35 miles of your home address, your assigned Contract Dentist must receive Authorization 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 authorized by Delta Dental will not be covered. Delta Dental will respond in writing to all Authorization requests for Specialist Services within five days of receipt.

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

Second Opinion

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

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases an Emergency Dental Condition will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service department at **800-422-4234** or write to Delta Dental.

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

Claims for Reimbursement

Claims for covered Emergency Services or preauthorized Specialist Services should be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Provider Compensation

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

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

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

Processing Policies

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

A Benefit appropriately provided through Teledentistry is covered on the same basis and to the same extent that the Benefit is covered through in-person diagnosis, consultation or treatment. The fee for Teledentistry services is considered inclusive in overall patient management and is not a separately payable service.

Coordination of Benefits

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

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

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

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

Enrollee Claims Complaint Procedure

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

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

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

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

Within 5 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you a written acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a regional dental consultant for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves an Emergency Dental Condition to a patient's dental health, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the complaint within three days.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care. You may file a complaint with the Department immediately you are experiencing an Emergency Dental Condition.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **800-422-4234** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an Emergency Dental Condition, 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 Dental Condition or urgent medical services. The Department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

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

Public Policy Participation by Enrollees

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

Termination of Benefits

All Benefits terminate for any Enrollee as of the date that this Program is terminated. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation, Rescission or Non-renewal of Coverage

We may cancel the Contract only:

- upon 30 days' written notice if Contractholder fails to pay premiums in the amount and as required by the Contract;
- upon 60 days' written notice if Contractholder fails to comply with material provisions relating to employer contribution or group participation rates by the Contractholder or employer of the Contract; or
- upon 60 days' written notice if We demonstrate that the Contractholder committed fraud or an intentional misrepresentation of material fact under the terms of the Contract.

Cancellation of Enrollment due to Non-Payment of Premium

Grace Period

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

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

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

Cancellation of Enrollment for other than Non-Payment of Premium

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

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

If the Contract is terminated for any cause, we are not required to preauthorize services beyond the termination date or to pay for services provided after the termination date, except for services begun while the Contract was in effect or if You have a cancellation grievance pending for reasons other than nonpayment of premium submitted prior to the effective date of Your cancellation, renewal or rescission. Please refer to the following *Grievance Regarding Cancellation, Rescission or Nonrenewal* section as well as the *Continuation of Benefits* sections.

RIGHT TO SUBMIT GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NONRENEWAL OF YOUR PLAN ENROLLMENT, SUBSCRIPTION OR CONTRACT

If You believe Your enrollment has been, or will be, improperly cancelled, rescinded or not renewed You have at least 180 days from the date of the notice You allege to be improper to submit a grievance to Us and/or the Department of Managed Health Care ("DMHC").

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

Reinstatement of Coverage

If it is determined the cancellation, rescission or nonrenewal, including a cancellation for nonpayment of premium, is improper, Your coverage may be reinstated retroactive to the date of cancellation, rescission or nonrenewal. The Contractholder or if You are responsible for paying Your premium may be responsible for the payment of any and all outstanding premium payments accrued from the effective date of the cancellation, rescission or nonrenewal before reinstatement. Any outstanding premium must be paid prior to reinstatement.

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

You may submit online at deltadentalins.com, or

Cancellation - Nonpayment: call 800-765-6003 or write to:
Delta Dental of California
Attn: Correspondence Department
P.O. Box 997330
Sacramento, CA 95899-7330

Cancellation - Rescission or Nonrenewal: call 866-275-1396 or write to:
DeltaCare USA
18000 Studebaker Road, Suite 530
Cerritos, CA 90703

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

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

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

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

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

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

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

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.

Timely Access to Care

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

a. For emergency care, 24 hours a day, 7 day days a week;
b. For any urgent care, 72 hours for appointments consistent with the patient's individual needs;
c. For any non-urgent care, 36 business days; and
d) For any preventative services, 40 business days.

During non-business hours, the Enrollee will have access to their Provider's answering machine, answering service, cell phone, or pager for guidance on what to do and who to contact if the Enrollee is calling due to an emergency or urgent care situation.

If an Enrollee calls our plan's customer service phone number, a Customer Service Representative will answer the phone within 10 minutes during normal business hours.

Should the Enrollee need interpretation services when scheduling an appointment with any of our Contract Dentists, Contract Orthodontists and Contract Specialists offices please call **800-422-4234** for assistance.

Non-Discrimination

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

Delta Dental:

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

If you need these services, contact our Customer Service Center at **800-422-4234**.

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

DeltaCare USA
18000 Studebaker Road, Suite 530
Cerritos, CA 90703
Telephone Number: **800-422-4234**
Website Address: deltadentalins.com

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

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

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

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the Contract Dentist subject to the *Limitations and Exclusions* of the Plan. Please refer to *Schedule B* for further clarification of Benefits. **You should discuss all treatment options with Your 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 Current Dental Terminology ("CDT"), CDT-2025 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

Code	Description	Enrollee Copay
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - comprehensive series of radiographic images - limited to 1 series every 12 months	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - limited to 1 series every 6 months	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0396	3D printing of a 3D dental surface scan	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - 1 every 12 months	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost

D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - 1 every 12 months	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - 1 every 12 months	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - 1 every 12 months	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost
D0709	Intraoral - comprehensive series of radiographic images – image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other services)	No Cost

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis cleaning - adult - 2 D1110, D1120 or D4346 per 12 month period	No Cost
D1110	Additional prophylaxis cleaning - adult (within the 12 month period)	$45.00
D1120	Prophylaxis cleaning - child - 2 D1110, D1120 or D4346 per 12 month period	No Cost
D1120	Additional prophylaxis cleaning - child (within the 12 month period)	$35.00
D1206	Topical application of fluoride varnish - child to age 19; 2 D1206 or D1208 per 12 month period	No Cost
D1208	Topical application of fluoride - excluding varnish - child to age 19; 2 D1206 or D1208 per 12 month period	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1320	Tobacco counseling for the control and prevention of oral disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - limited to permanent molars through age 15	No Cost
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - limited to permanent molars through age 15	No Cost
D1353	Sealant repair - per tooth - limited to permanent molars through age 15	No Cost
D1354	Application of caries arresting medicament - per tooth - child to age 19; 2 per 12 month period	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	No Cost
D1516	Space maintainer - fixed - bilateral, maxillary	No Cost
D1517	Space maintainer - fixed - bilateral, mandibular	No Cost
D1520	Space maintainer - removable - unilateral - per quadrant	No Cost
D1526	Space maintainer - removable - bilateral, maxillary	No Cost

D1527	Space maintainer - removable - bilateral, mandibular	No Cost
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No Cost
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No Cost
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No Cost
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Cost
D1557	Removal of fixed bilateral space maintainer - maxillary	No Cost
D1558	Removal of fixed bilateral space maintainer - mandibular	No Cost
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - child to age 9	No Cost

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior	$65.00
D2392	Resin-based composite - two surfaces, posterior	$75.00
D2393	Resin-based composite - three surfaces, posterior	$85.00
D2394	Resin-based composite - four or more surfaces, posterior	$95.00
D2510	Inlay - metallic - one surface [1, 4]	No Cost
D2520	Inlay - metallic - two surfaces [1, 4]	No Cost
D2530	Inlay - metallic - three or more surfaces [1, 4]	No Cost
D2542	Onlay - metallic - two surfaces [1, 4]	No Cost
D2543	Onlay - metallic - three surfaces [1, 4]	No Cost
D2544	Onlay - metallic - four or more surfaces [1, 4]	No Cost
D2610	Inlay - porcelain/ceramic - one surface	$200.00
D2620	Inlay - porcelain/ceramic - two surfaces	$250.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$300.00
D2642	Onlay - porcelain/ceramic - two surfaces	$270.00
D2643	Onlay - porcelain/ceramic - three surfaces	$340.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$370.00
D2650	Inlay - resin-based composite - one surface	$100.00
D2651	Inlay - resin-based composite - two surfaces	$150.00
D2652	Inlay - resin-based composite - three or more surfaces	$200.00
D2662	Onlay - resin-based composite - two surfaces	$150.00
D2663	Onlay - resin-based composite - three surfaces	$200.00
D2664	Onlay - resin-based composite - four or more surfaces	$250.00
D2710	Crown - resin-based composite (indirect) [1, 8]	$50.00
D2712	Crown - 3/4 resin-based composite (indirect) [1, 8]	$50.00
D2720	Crown - resin with high noble metal [1, 8]	$150.00
D2721	Crown - resin with predominantly base metal [1, 8]	$50.00
D2722	Crown - resin with noble metal [1, 8]	$50.00
D2740	Crown - porcelain/ceramic [1, 8]	$50.00
D2750	Crown - porcelain fused to high noble metal [1, 8]	$150.00
D2751	Crown - porcelain fused to predominantly base metal [1, 8]	$50.00
D2752	Crown - porcelain fused to noble metal [1, 8]	$50.00
D2753	Crown - porcelain fused to titanium and titanium alloys [1, 8]	$150.00
D2780	Crown - 3/4 cast high noble metal [1]	$150.00

D2781	Crown - 3/4 cast predominantly base metal [1]	$50.00
D2782	Crown - 3/4 cast noble metal [1]	$50.00
D2783	Crown - 3/4 porcelain/ceramic [1]	$50.00
D2790	Crown - full cast high noble metal [1]	$150.00
D2791	Crown - full cast predominantly base metal [1]	$50.00
D2792	Crown - full cast noble metal [1]	$50.00
D2794	Crown - titanium and titanium alloys [1]	$150.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp (anterior)	No Cost
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - anterior	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - anterior primary tooth	No Cost
D2933	Prefabricated stainless steel crown with resin window – anterior primary tooth	No Cost
D2940	Placement of interim direct restoration	No Cost
D2949	Restorative foundation for an indirect restoration	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated – includes canal preparation [4]	No Cost
D2953	Each additional indirectly fabricated post - same tooth – includes canal preparation [4]	No Cost
D2954	Prefabricated post and core in addition to crown - base metal post; includes canal preparation	No Cost
D2956	Removal of indirect restoration on a natural tooth	No Cost
D2957	Each additional prefabricated post - same tooth - base metal post; includes canal preparation	No Cost
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	$10.00
D2976	Band stabilization – per tooth – limited to once in a lifetime per tooth	No Cost
D2980	Crown repair necessitated by restorative material failure	No Cost
D2981	Inlay repair necessitated by restorative material failure	No Cost
D2982	Onlay repair necessitated by restorative material failure	No Cost
D2983	Veneer repair necessitated by restorative material failure	No Cost
D2989	Excavation of a tooth resulting in the determination of non-restorability	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - limited to permanent molars through age 15	No Cost
D2991	Application of hydroxyapatite regeneration medicament – per tooth – limited to twice per tooth in a 12 month period	No Cost

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	No Cost

D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Cost
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	No Cost
D3310	Root canal - endodontic therapy, anterior tooth (excluding final restoration) [9]	$20.00
D3320	Root canal - endodontic therapy, premolar tooth (excluding final restoration) [9]	$40.00
D3330	Root canal - endodontic therapy, molar tooth (excluding final restoration) [9]	$60.00
D3331	Treatment of root canal obstruction; non-surgical access	$45.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$45.00
D3333	Internal root repair of perforation defects	$45.00
D3346	Retreatment of previous root canal therapy - anterior [9]	$20.00
D3347	Retreatment of previous root canal therapy - premolar [9]	$40.00
D3348	Retreatment of previous root canal therapy - molar [9]	$60.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior [9]	No Cost
D3421	Apicoectomy - premolar (first root) [9]	No Cost
D3425	Apicoectomy - molar (first root) [9]	No Cost
D3426	Apicoectomy (each additional root) [9]	No Cost
D3430	Retrograde filling - per root [9]	No Cost
D3450	Root amputation, per root - not covered in conjunction with a hemisection [9]	No Cost
D3471	Surgical repair of root resorption - anterior	No Cost
D3472	Surgical repair of root resorption - premolar	No Cost
D3473	Surgical repair of root resorption - molar	No Cost
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	No Cost
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	No Cost
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	No Cost

D4000-D4999 V. PERIODONTICS

- *Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.*

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost

D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$100.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$100.00
D4270	Pedicle soft tissue graft procedure	$150.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$150.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$150.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - limited to 5 quadrants during any 12 consecutive months	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - limited to 5 quadrants during any 12 consecutive months	No Cost
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - 2 D1110, D1120 or D4346 per 12 month period	No Cost
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - limited to 1 treatment in any 12 consecutive months	No Cost
D4910	Periodontal maintenance - limited to 1 treatment each 6 month period	No Cost
D4910	Additional periodontal maintenance (within the 6 month period)	$55.00
D4921	Gingival irrigation with a medicinal agent - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110	Complete denture - maxillary [2, 5]	$65.00
D5120	Complete denture - mandibular [2, 5]	$65.00
D5130	Immediate denture - maxillary [2, 5]	$65.00
D5140	Immediate denture - mandibular [2, 5]	$65.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) [2, 5]	$65.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) [2, 5]	$65.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) [2, 5]	$65.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) [2, 5]	$65.00
D5221	Immediate maxillary partial denture - resin base (including retentive /clasping materials, rests, and teeth)	$65.00
D5222	Immediate mandibular partial denture - resin base (including retentive /clasping materials, rests, and teeth)	$65.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$65.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$65.00

D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery [2, 5]	$115.00
D5226	Mandibular partial denture - flexible base (including retentive /clasping materials, rests, and teeth) [2, 5]	$115.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$65.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$65.00
D5410	Adjust complete denture - maxillary [5]	No Cost
D5411	Adjust complete denture - mandibular [5]	No Cost
D5421	Adjust partial denture - maxillary [5]	No Cost
D5422	Adjust partial denture - mandibular [5]	No Cost
D5511	Repair broken complete denture base, mandibular	No Cost
D5512	Repair broken complete denture base, maxillary	No Cost
D5520	Replace missing or broken teeth - complete denture (per tooth)	No Cost
D5611	Repair resin partial denture base, mandibular	No Cost
D5612	Repair resin partial denture base, maxillary	No Cost
D5621	Repair cast partial framework, mandibular	No Cost
D5622	Repair cast partial framework, maxillary	No Cost
D5630	Repair or replace broken retentive/clasping materials - per tooth	No Cost
D5640	Replace missing or broken teeth - partial denture - per tooth	No Cost
D5650	Add tooth to existing partial denture – per tooth	No Cost
D5660	Add clasp to existing partial denture - per tooth	No Cost
D5710	Rebase complete maxillary denture [7]	$20.00
D5711	Rebase complete mandibular denture [7]	$20.00
D5720	Rebase maxillary partial denture [7]	$20.00
D5721	Rebase mandibular partial denture [7]	$20.00
D5725	Rebase hybrid prosthesis	$20.00
D5730	Reline complete maxillary denture (chairside) [7]	No Cost
D5731	Reline complete mandibular denture (chairside) [7]	No Cost
D5740	Reline maxillary partial denture (chairside) [7]	No Cost
D5741	Reline mandibular partial denture (chairside) [7]	No Cost
D5750	Reline complete maxillary denture (laboratory) [7]	No Cost
D5751	Reline complete mandibular denture (laboratory) [7]	No Cost
D5760	Reline maxillary partial denture (laboratory) [7]	No Cost
D5761	Reline mandibular partial denture (laboratory) [7]	No Cost
D5765	Soft liner for complete or partial removable denture - indirect	No Cost
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing[5]	No Cost
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing [5]	No Cost
D5850	Tissue conditioning, maxillary [5, 7]	No Cost
D5851	Tissue conditioning, mandibular [5, 7]	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES

- *Implant services are not a covered benefit*
- *Prosthetic implant services, (implant abutments, implant supported crowns, retainers and dentures) are considered optional services and an alternate benefit may be provided for these procedures, subject to Limitation 12*

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

D6205	Pontic - indirect resin based composite [10]	$50.00
D6210	Pontic - cast high noble metal [10]	$150.00
D6211	Pontic - cast predominantly base metal [10]	$50.00
D6212	Pontic - cast noble metal [10]	$50.00
D6214	Pontic - titanium and titanium alloys [10]	$150.00
D6240	Pontic - porcelain fused to high noble metal [8, 10]	$150.00
D6241	Pontic - porcelain fused to predominantly base metal [8, 10]	$50.00
D6242	Pontic - porcelain fused to noble metal [8, 10]	$50.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$50.00
D6245	Pontic - porcelain/ceramic [8, 10]	$50.00
D6250	Pontic - resin with high noble metal [8, 10]	$150.00
D6251	Pontic - resin with predominantly base metal [8, 10]	$50.00
D6252	Pontic - resin with noble metal [8, 10]	$50.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces [10]	$250.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces [10]	$300.00
D6602	Retainer inlay - cast high noble metal, two surfaces [10]	$100.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces [10]	$100.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces [10]	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces [10]	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces [10]	No Cost
D6607	Retainer inlay - cast noble metal, three or more surfaces [10]	No Cost
D6608	Retainer onlay - porcelain/ceramic, two surfaces [10]	$270.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces [10]	$370.00
D6610	Retainer onlay - cast high noble metal, two surfaces [10]	$100.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces [10]	$100.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces 1[0]	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces 1[0]	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces [10]	No Cost
D6615	Retainer onlay - cast noble metal, three or more surfaces 1[0]	No Cost
D6710	Retainer crown - indirect resin based composite 1[0]	$50.00
D6720	Retainer crown - resin with high noble metal [8, 10]	$150.00
D6721	Retainer crown - resin with predominantly base metal 8[, 10]	$50.00
D6722	Retainer crown - resin with noble metal [8, 10]	$50.00
D6740	Retainer crown - porcelain/ceramic [8, 10]	$50.00
D6750	Retainer crown - porcelain fused to high noble metal [8, 10]	$150.00
D6751	Retainer crown - porcelain fused to predominantly base metal [8, 10]	$50.00
D6752	Retainer crown - porcelain fused to noble metal [8, 10]	$50.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$150.00
D6780	Retainer crown - 3/4 cast high noble metal [10]	$150.00

D6781	Retainer crown - 3/4 cast predominantly base metal [10]	$50.00
D6782	Retainer crown - 3/4 cast noble metal [10]	$50.00
D6783	Retainer crown - 3/4 porcelain/ceramic [10]	$50.00
D6784	Retainer crown - 3/4 titanium and titanium alloys	$150.00
D6790	Retainer crown - full cast high noble metal [10]	$150.00
D6791	Retainer crown - full cast predominantly base metal [10]	$50.00
D6792	Retainer crown - full cast noble metal [10]	$50.00
D6794	Retainer crown - titanium and titanium alloys [10]	$150.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker [10]	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	No Cost

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- *Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.*

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No Cost
D7220	Removal of impacted tooth - soft tissue	$15.00
D7230	Removal of impacted tooth - partially bony	$15.00
D7240	Removal of impacted tooth - completely bony	$15.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$15.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	$15.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$50.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7284	Excisional biopsy of minor salivary glands	No Cost
D7286	Incisional biopsy of oral tissue - soft - does not include pathology laboratory procedures	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7410	Excision of benign lesion up to 1.25 cm	No Cost
D7411	Excision of benign lesion greater than 1.25 cm	No Cost
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost

D7471	Removal of lateral exostosis (maxilla or mandible) - per site	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7509	Marsupialization of odontogenic cyst	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7880	Occlusal orthotic device, by report - occlusal orthotic device and guards are a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction	No Cost
D7881	Occlusal orthotic device adjustment - occlusal orthotic device and guards are a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost
D7970	Excision of hyperplastic tissue - per arch	$50.00
D7971	Excision of pericoronal gingiva	$50.00

D8000-D8999 XI. ORTHODONTICS

	Pre and post orthodontic records include: *The Benefit for pre-treatment records and diagnostic services includes:*	No Cost
D0210	Intraoral - comprehensive series of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intraorally or extraorally	
D0396	3D printing of a 3D dental surface scan	
D0470	Diagnostic casts	
D0801	3D intraoral surface scan - direct	
D0802	3D dental surface scan - indirect	
D0803	3D facial surface scan – direct	
D0804	3D facial surface scan – indirect	
	The Benefit for post-treatment records includes:	No Cost
D0210	Intraoral - comprehensive series of radiographic images	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	$910.00
D8020	Limited orthodontic treatment of the transitional dentition - child or adolescent to age 19	$990.00
D8030	Limited orthodontic treatment of the adolescent dentition - adolescent to age 19	$1,160.00
D8040	Limited orthodontic treatment of the adult dentition - adults, including covered dependent adult children	$1,175.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - child or adolescent to age 19 [6]	$1,000.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - adolescent to age 19 [6]	$1,000.00
D8090	Comprehensive orthodontic treatment of the adult dentition - adults, including covered dependent adult children [6]	$1,000.00
D8091	Comprehensive orthodontic treatment with orthognathic surgery	$1,150.00

D8660	Pre-orthodontic treatment examination to monitor growth and development - not to be charged with any other consultation procedure(s) [11]	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) [3]	No Cost
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - includes the START-UP FEE, which includes initial examination, diagnosis, consultation and initial banding	No Cost

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative treatment of dental pain - per visit	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes – limitations apply. Refer to Schedule B, Limitation #10	No Cost
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment - limitations apply. Refer to Schedule B, Limitation #10	No Cost
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes - limitations apply. Refer to Schedule B, Limitation #10	No Cost
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment - limitations apply. Refer to Schedule B, Limitation #10	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	$0.00
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	No Cost
D9944	Occlusal guard - hard appliance, full arch - occlusal orthotic device and guards are a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction	No Cost
D9945	Occlusal guard - soft appliance, full arch - occlusal orthotic device and guards are a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction	No Cost
D9946	Occlusal guard - hard appliance, partial arch - occlusal orthotic device and guards are a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction	No Cost

D9951	Occlusal adjustment, limited - a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction	No Cost
D9952	Occlusal adjustment, complete - a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction	No Cost
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - limited to one bleaching tray and gel for two weeks of self-treatment	$125.00
D9986	Missed appointment - without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00	$10.00
D9987	Canceled appointment - without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

Procedures with age restrictions will be subject to exceptions based on medical necessity.

Teledentistry services provided by a Dentist other than Your Contract Dentist are considered Out-of-Network and may result in an out of-pocket cost to You, unless coverage is required under other law.

FOOTNOTES

[1] *Replacement is subject to a limitation requiring the existing restoration to be 3+ years old.*

[2] *Replacement is subject to a limitation requiring the existing denture to be 3+ years old.*

[3] *Includes adjustments and/or office visits up to 36 months. After 36 months, a monthly fee of $75.00 applies.*

[4] *If an indirectly fabricated post and core, inlay or onlay is made of high noble metal, an additional fee up to $100.00 per tooth will be charged for the upgrade.*

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

[6] *Listed Copayment covers up to 36 months of active orthodontic treatment excluding the services listed for D8999 "Start-up fee." Beyond 36 months of active treatment, an additional monthly fee of $75.00 applies.*

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

[8] *Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge of $150.00.*

[9] *A Benefit for permanent teeth only.*

10 Replacement is subject to a limitation requiring the existing bridge to be 3+ years old.

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

12 Optional is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by You, and is subject to the Limitations and Exclusions of the Plan. The applicable charge is the difference between the Contract Dentist's submitted fee for the Optional procedure and the submitted fee for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are benefits. Submitted means the Contract Dentist's fees on file with Us.

SCHEDULE B

Limitations and Exclusions below with age restrictions will be subject to exceptions based on medical necessity.

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*

2. Benefits for sealants include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars through age nine and second molars through age 15. Benefits for sealants do not include the repair or replacement of a sealant on any tooth within three years of its application.

3. If a porcelain margin is also chosen by You for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is $75.00.

4. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:

   - The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, and

   - Either of the following

     - The existing non-functional restoration/bridge/denture was placed three or more years prior to its replacement, or

     - If an existing partial denture is less than three years old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.

5. A fixed bridge is considered standard dental treatment when it is necessary to replace one missing permanent anterior tooth in a person 16 years old or older. Such treatment will be covered if the patient's oral health and general dental condition permits.

   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. A fixed bridge used under these circumstances is considered Optional Treatment.

   Fixed bridges are not a Benefit when provided in connection with a partial denture on the same arch. If provided, it is considered Optional treatment.

   Replacement of an existing nonfunctional bridge is limited to once in a three year period and shall be covered only when the replacement duplicates the original bridge.

   Fixed bridges are not a benefit for Dependent Enrollees under the age of 16. A fixed bridge under these circumstances is considered Optional Treatment.

   Optional Treatment procedures are defined below.

6. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to:

   - The replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture or

   - The replacement of permanent tooth/teeth for children under 16 years of age.

7 Benefits provided by a pediatric Dentist are limited to children through age thirteen (13) less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

8 In cases of accidental injury, benefits available are described in *Schedule B.* Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function, exclusive attrition and normal wear, will be covered as described in *Schedule A and B.*

9 An Optional procedure is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by You, and is subject to the Limitations and Exclusions of the Plan. The applicable charge is the difference between the Contract Dentist's submitted fee for the Optional Treatment and the submitted fees for the covered procedure, plus any applicable Copayment for the covered procedure. Optional Treatment does not apply when alternative choices are Benefits.

10 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).

11 The Contract Dentist has the right to refuse treatment if You continually fail to follow a prescribed course of treatment.

12 If implants are utilized, We will allow the cost of a single standard full or partial denture toward the cost of appliances constructed thereon (Optional Treatment formula). You are responsible for the Optional Treatment fee if implants are used. The DeltaCare USA Plan does not cover the surgical removal of implants.

13 The cost to You receiving orthodontic treatment when coverage is cancelled or terminated for any reason will be based on a maximum of $1,400.00 for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. You make payment directly to the Contract Orthodontist as arranged.

Should this Contract be terminated by either party due to breach or non-renewal at the end of any applicable term, the provision above will apply with respect being treated for orthodontic work which is not completed at the date of termination. Your payment will be no more than $1,000.00.

14 Orthodontic treatment in progress is available to You, if at the time of Your original effective date, You are in active treatment started under Your previous group dental plan, as long as You continue to be eligible under the DeltaCare USA Plan. Active treatment means tooth movement has begun. You are responsible for all Copayments and fees subject to the provisions of Your prior dental plan. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

15 Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are Benefits. If any additional recementations or replacements of brackets/bands are performed, You are responsible for the cost at the Contract Orthodontist's submitted fee.

16 Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the Contract Orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same Copayment amounts as for fixed appliances.

17 Teledentistry services provided by a Dentist other than Your Contract Dentist are considered Out-of-Network and may result in an out-of-pocket cost to You, unless coverage is required under other law,

18 Coverage for orthodontic treatment is limited to conventional orthodontic services, which includes clear aligner therapy (e.g., Invisalign™ and Sure Smile™). We consider lingual brackets, clear (composite or ceramic) brackets to be specialized services. When treatment using lingual brackets or clear (composite or ceramic) brackets is provided, We will make an allowance for conventional orthodontic services. You are responsible for Your Copayment for the conventional orthodontic treatment plus the additional fees related to the specialized services (lingual brackets or clear brackets).

19 X-ray Limitations:

- When the frequencies for the comprehensive radiographic images (D0210) and panoramic radiographic images (D0330) differ, the least restrictive frequency will apply.
- Panoramic images are not considered part of a comprehensive intraoral series.
- Bitewing x-rays of any type are included in the fee of a comprehensive series when taken within 6 months of the comprehensive images.
- Bitewing x-rays are limited to two images for under age 10.
- Image capture procedures are not separately billable services.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.

2. Any procedure that in the professional opinion of the Contract Dentist:

    a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or

    b. is inconsistent with generally accepted standards for dentistry.

3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch).

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

5. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).

6. Dental expenses incurred in connection with any dental procedure started before Your eligibility with the DeltaCare USA Plan. Examples include: teeth prepared for crowns, root canals in progress, orthodontics, unless qualified for the orthodontic treatment in progress. See limitations

7. Prescription drugs.

8. Dental services received from any dental facility other than the Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for Emergency Services as described in the Evidence of Coverage.

9. Consultations for non-covered Benefits.

10. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.

11. Procedures, appliances (other than an occlusal orthotic device) or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).

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

13. 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.

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

15. Services and benefits provided by You, or any Dependent Enrollee, or by Your spouse, child, brother, sister, parent, or other relative.

16. Lost, stolen or broken orthodontic appliances.

17. Retreatment of orthodontic cases.

18. Changes in orthodontic treatment necessitated by accident of any kind.

19. Surgical procedures incidental to orthodontic treatment.

20. Myofunctional therapy.

21. Extractions solely for the purpose of orthodontics.

22. Transfer after banding has been initiated.

23. Orthodontic treatment must be provided by a licensed Dentist.

24. Services or supplies for sleep apnea.

Temporomandibular Joint Benefit

We will pay 100% of the Dentist's submitted fees or of the fees actually charged for all covered temporomandibular joint (TMJ) procedures, as noted herein. TMJ benefits are intended only for the treatment of temporomandibular (jaw) joint and are limited to the procedures noted below when provided by a licensed dentist as necessary and customary according to the standards of generally accepted dental practice and only when provided for the treatment of TMJ dysfunction:

- D7880 Occlusal orthotic device, by report

- D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)

- D9944, D9945, D9946, Occlusal guards

- D9951 Occlusal adjustment - limited

- D9952 Occlusal adjustment – complete

Limitations and Exclusions of TMJ Benefits

TMJ benefits are subject to *Schedule B*and any definitions and/or other terms of the Contract not in conflict with the express terms of this Benefit in addition to the following:

1. The replacement of lost, missing or stolen appliances furnished in whole or in part under this benefit or any other TMJ benefit are not covered.

2. Repair and replacement of covered TMJ devices may be made only after three years have elapsed following any prior provision of such appliances under this Plan or any other plan, except when it is determined that there is such extensive change in the patient's condition (such as the loss of a tooth or teeth) that the appliance cannot be made functional. If the TMJ device is not functional resulting from abuse or alteration by You, this Benefit is excluded.

3. Fixed appliances and restorations provided solely for the treatment of TMJ are excluded. (Note: an occlusal orthotic device is a removable appliance (not "fixed"). Fixed appliances, like fixed partial dentures or crowns placed for the treatment of TMJ, would be excluded.)

4. Diagnostic procedures not otherwise covered are excluded.

5. Services for bruxism (grinding of teeth) unrelated to TMJ dysfunction are not covered.

Dental Implants

While dental implant procedures are not a Benefit under the Plan, the DeltaCare USA Plan allows for an optional Benefit toward prosthetic appliances placed on implants. Please review limitations Clarify the charges with your Contract dentist prior to starting treatment. Not all Contract dentists provide this service, and this optional Benefit is not available out-of-network.

Dental Accident Benefits

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

Dental Accident is an external blow or other trauma (fall, fist, car accident, gunshot wound, etc.) that would cause severe damage to the dentition, or an internal accident such as biting into glass or a stone that causes severe tooth damage.

Services necessary as a result of a dental accident may be covered as primary under Your medical coverage. All claims should first be submitted to Your medical carrier for review and possible payment, prior to submitting them under the DeltaCare USA plan.

Your medical plan's customer service representatives will be able to confirm the coverage for dental accidents.

If services necessary as a result of a dental accident are not covered under Your medical coverage, Wel will pay up to 100% of the Contract Dentist's submitted fees for expenses You incur for an accidental injury, less any applicable Copayments.

Accident injury benefits include the following procedure in addition to those listed in

Schedule A.

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

Payment of accident injury Benefits is subject to *Schedule B*.

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

Toll Free
800-422-4234

Delta Dental of California
18000 Studebaker Road, Suite 530
Cerritos, CA 90703

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Non-Discrimination

Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Company:

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

If you need these services, contact our Customer Service Center at 800-471-9925.

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

DeltaCare USA
18000 Studebaker Road, Ste. 530
Cerritos, CA 90703
Telephone Number: 800-471-9925
Website Address: https://www1.deltadentalins.com/group-sites/uc.html

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

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

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