

Dental Health Care Program for  
Eligible Retirees and Dependents

***Combined Evidence of Coverage  
and Disclosure Form***

**County of San Bernardino**

*Provided 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  
855-244-7323

deltadentalins.com

# EVIDENCE OF COVERAGE

## DISCLOSURE FORM

DeltaCare® USA Dental HMO Program

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

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

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

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

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

*IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a Contract Dentist may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered bene?t, 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 855-244-7323 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.*

**The telephone number where you may obtain information about Bene?ts is 855-244-7323.**

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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.

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

**Benefits:** Dental services provided by Us as described in this EOC, the Contract and Schedules. See also Schedules.

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

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

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

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

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

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

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

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

**Emergency Service** means care provided by a Dentist to treat a dental condition which manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the Enrollee to result in either: (i)

placing the Enrollee's dental health in serious jeopardy, or (ii) serious impairment to dental functions.

**Enrollee** ("Primary Enrollee"): Employee or a Dependent ("Dependent Enrollee") enrolled to receive Benefits.

**Open Enrollment Period** means the period requested by the Client and agreed to by Delta Dental.

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

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

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

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

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

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

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

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

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

## **Eligibility for Benefits**

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

### Employee Eligibility

To be eligible for the benefits you must be:

- 1) An employee in a regular position scheduled to work a minimum of 40 hours per pay period and have received pay for at least one half plus one hour of your scheduled hours (or be on an approved leave pursuant to applicable law).
- 2) Your coverage begins on the first day of the pay period following the pay period in which premiums are first collected.
- 3) Safety employees must be scheduled and paid for a minimum of 41 hours a pay period. The benefit must be offered to you through a Memorandum of Understanding (MOU), Compensation Plan, Contract or Salary Ordinance.

### Dependent Eligibility

If you are eligible to participate in County-sponsored dental plans, your eligible spouse, domestic partner or dependents may also participate if they meet one of the following criteria:

- 1) Legal spouse or state-registered domestic partner.
- 2) Your qualifying children which includes children up to age 26 that are born to you, your stepchildren, children legally adopted by you (including children legally placed in your home while finalization of adoption is pending), children for whom you are the permanent legal guardian, children of a domestic partner, and children you support as a result of a valid court order.

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

Parents, grandparents, grandchildren, common-law spouses, divorced spouses, roommates, and relatives other than those listed above are not eligible for County-sponsored dental plans.

### **Prepayment Fees/Premiums**

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly.

We may cancel the Contract 30 days after written notice to the Client if monthly premiums are not paid when due. The Client will be given a 60 day grace period, which begins immediately following the last day of paid coverage, to pay the monthly premium. During that time, Delta Dental will continue to provide coverage to Enrollees. If the premium remains unpaid at the end of the 60 day grace period, the Contractholder will notify you that coverage has terminated along with the date of termination.

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

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department



at 855-244-7323. 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 855-244-7323.

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

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

## **Continuity of Care**

Current Members:

You may have the right to the benefit of completion of care with your terminated Dentist for certain specified dental conditions. Please call Customer Service at 855-244-7323 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 855-244-7323 to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your current Dentist. We are not required to continue your care with that Dentist if you are not eligible under our policy or if we cannot reach agreement with your Dentist on the terms regarding your care in accordance with California law. This policy does not apply to new Members of an individual subscriber contract.

## Special Needs

If an Enrollee believes he or she has a Special Health Care Need, the Enrollee should contact Delta Dental's Customer Service department at 855-244-7323. Delta Dental will confirm that a Special Health Care Need exists, and what arrangements can be made to assist the Enrollee in obtaining such Benefits. Delta Dental shall not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Dentist treating persons with Special Health Care Needs.

## Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service department at 855-244-7323.

## Benefits, Limitations and Exclusions

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

## Copayments and Other Charges

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 Services**

If Emergency Services are needed, you should contact your Contract Dentist whenever possible. If you are a new Enrollee needing Emergency Services, but do not have an assigned Contract Dentist yet, contact Delta Dental's Customer Service department at 855-244-7323 for help in locating a Contract Dentist. Benefits for Emergency Services by an Out-of-Network Dentist are limited to necessary care to stabilize your condition and/or provide palliative relief when you:

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

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

### **Specialist Services**

Specialist Services must be referred by the assigned Contract Dentist and preauthorized in writing by Delta Dental. All preauthorized Specialist Services will be paid by us less any applicable Copayments. If an Enrollee is assigned to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

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

## **Second Opinion**

You may request a second opinion if You disagree with or question the diagnosis and/or treatment plan determination made by Your Contract Dentist. 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 of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service department at 855-244-7323 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 855-244-7323 for information regarding the dental care guidelines for DeltaCare USA.

## **Coordination of Benefits**

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

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

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

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

## **Enrollee Complaint Procedure**

Delta Dental shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 855-244-7323, or the complaint may be addressed in writing to:

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

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

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

review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 5 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a regional dental consultant for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves severe pain and/or imminent and serious threat to a patient's dental health, Delta Dental will provide the Enrollee notification regarding the disposition or pending status of the complaint shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours.

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

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **855-244-7323** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing

and speech impaired. The Department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

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

### **Public Policy Participation by Enrollees**

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

### **Renewal and Termination of Benefits**

This Program renews on the anniversary of the contract term unless Delta Dental provides notice of a change in premiums or Benefits and the Client does not accept the change.

### **When Coverage Ends**

#### Employees

Your benefits will cease on the earliest date below:

- 1) The last day of the pay period in which:
  - a. If you are an Employee in a regular position, you have less than 40 hours of paid time.
  - b. If you are a Safety employee, you have less than 41 hours of paid time.
- 2) The last day for which you have made any required contribution for the coverage.
- 3) The date the policy is canceled.

#### Dependents

The benefits for all of your Dependent Enrollees will cease on the earliest date below:

- 1) The date your coverage ceases.
- 2) The date your Dependent(s) cease to be eligible for coverage.



- 3) The last day for which you have made any required contribution for the coverage.

Your Dependent Enrollee's coverage ends when yours does, or the pay period in which they are no longer eligible Dependents.

### **Cancellation of Enrollment**

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

- 1) immediately:
  - a) Upon loss of eligibility as described in this EOC; or
- 2) upon 30 days written notice if:
  - a) the Contract is terminated or not renewed;
  - b) the Premium is not paid by or on behalf of the Enrollee on the date due. However, the Enrollee may continue to receive Benefits during the 60-day grace period and may be renewed at the end of the Contract Term upon payment of any unpaid Premium; or
  - c) Delta Dental demonstrates that the Enrollee committed fraud or an intentional misrepresentation of material fact in obtaining Benefits under the Program.

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

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

### **Optional Continuation of Coverage (COBRA)**

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

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage

under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event and whether the Enrollee is covered under federal COBRA.

## DEFINITIONS

The meaning of key terms used in this section is shown below and applies to federal COBRA.

**Qualified Beneficiary** means:

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

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

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

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

## PERIODS OF CONTINUED COVERAGE UNDER FEDERAL COBRA

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

This 18-month period can be extended for a total of 29 months, provided:

- 1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the

- Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
- 2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

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

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

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

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

## ELECTION OF CONTINUED COVERAGE

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

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

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

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

## CONTINUED COVERAGE BENEFITS

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

## TERMINATION OF CONTINUED COVERAGE

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

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

Once continued coverage ends, it cannot be reinstated.

## TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect

continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Delta Dental plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

## OPEN ENROLLMENT CHANGE OF COVERAGE

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

## Organ and Tissue Donation

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

## Non-Discrimination

Delta Dental is committed to ensuring that no person is excluded from, or denied the benefits of our services, or otherwise discriminated against on the basis of race, color, national origin, disability, age, genetic testing, sexual orientation or gender identity. Any person who believes that he or she has individually, or as a member of any specific class of persons, been subjected to discrimination may file a complaint in writing to:

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

## **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
- 4) 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 855-244-7323 for assistance.

# 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-2023 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.**

<u>CODE</u>	<u>DESCRIPTION</u>	<u>ENROLLEE PAYS</u>
<b>D0100-D0999</b>	<b>I. DIAGNOSTIC</b>	
D0120	Periodic oral evaluation - established patient .....	No Cost
D0140	Limited oral evaluation - problem focused .....	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver .....	No Cost
D0150	Comprehensive oral evaluation - new or established patient .....	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report .....	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit) .....	No Cost
D0171	Re-evaluation - post-operative office visit .....	\$5.00
D0180	Comprehensive periodontal evaluation - new or established patient .....	No Cost
D0190	Screening of a patient .....	No Cost
D0191	Assessment of a patient .....	No Cost
D0210	Intraoral - comprehensive series of radiographic images - <i>limited to 1 series every 24 months</i> .....	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 .....	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images .....	No Cost
D0330	Panoramic radiographic image - <i>limited to 1 every 3 years</i> .....	No Cost
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report .....	No Cost
D0415	Collection of microorganisms for culture and sensitivity .....	No Cost
D0419	Assessment of salivary flow by measurement - <i>1 every 12 months</i> .....	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 - <i>1 every 12 months</i> .....	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 12 months</i> .....	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 12 months</i> .....	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 - <i>includes office visit, per visit (in addition to other services)</i> .....	No Cost

**D1000-D1999                      II. PREVENTIVE**

D1110	Prophylaxis <i>cleaning</i> - adult - 2 D1110, D1120 or D4346 per calendar year .....	No Cost
D1110	<i>Additional prophylaxis cleaning - adult (In addition to the 2 allowed per calendar year)</i> .....	\$45.00
D1120	Prophylaxis <i>cleaning</i> - child - 2 D1110, D1120 or D4346 per calendar year .....	No Cost
D1120	<i>Additional prophylaxis cleaning - child (In addition to the 2 allowed per calendar year)</i> .....	\$35.00
D1206	Topical application of fluoride varnish - <i>child to age 19; 2 D1206 or D1208 per calendar year</i> .....	No Cost
D1208	Topical application of fluoride - excluding varnish - <i>2 D1206 or D1208 per calendar year</i> .....	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions .....	No Cost
D1351	Sealant - per tooth .....	\$5.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth .....	\$5.00
D1353	Sealant repair - per tooth .....	\$3.00
D1354	Application of caries arresting medicament - per tooth - <i>2 per calendar year</i> .....	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	\$15.00
D1516	Space maintainer - fixed - bilateral, maxillary .....	\$15.00

D1517	Space maintainer - fixed - bilateral, mandibular .....	\$15.00
D1520	Space maintainer - removable - unilateral - per quadrant .....	\$15.00
D1526	Space maintainer - removable - bilateral, maxillary .	\$15.00
D1527	Space maintainer - removable - bilateral, mandibular .....	\$15.00
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 - <i>child to age 9</i> .....	\$17.00

**D2000-D2999 III. RESTORATIVE**

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

- When there are more than six crowns in the same treatment plan, You may be charged an additional \$100.00 per crown, beyond the 6th unit.

- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

D2140	Amalgam - one surface, primary or permanent .....	No Cost
D2150	Amalgam - two surfaces, primary or permanent ....	No Cost
D2160	Amalgam - three surfaces, primary or permanent ..	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent .....	No Cost
D2330	Resin-based composite - one surface, anterior .....	No Cost
D2331	Resin-based composite - two surfaces, anterior ....	No Cost
D2332	Resin-based composite - three surfaces, anterior ...	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) .....	No Cost
D2390	Resin-based composite crown, anterior .....	No Cost
D2391	Resin-based composite - one surface, posterior ....	\$45.00

D2392	Resin-based composite - two surfaces, posterior ...	\$55.00
D2393	Resin-based composite - three surfaces, posterior .	\$65.00
D2394	Resin-based composite - four or more surfaces, posterior .....	\$75.00
D2510	Inlay - metallic - one surface .....	No Cost
D2520	Inlay - metallic - two surfaces .....	No Cost
D2530	Inlay - metallic - three or more surfaces .....	No Cost
D2542	Onlay - metallic - two surfaces .....	No Cost
D2543	Onlay - metallic - three surfaces .....	No Cost
D2544	Onlay - metallic - four or more surfaces .....	No Cost
D2610	Inlay - porcelain/ceramic - one surface .....	\$135.00
D2620	Inlay - porcelain/ceramic - two surfaces .....	\$150.00
D2630	Inlay - porcelain/ceramic - three or more surfaces ..	\$160.00
D2642	Onlay - porcelain/ceramic - two surfaces .....	\$150.00
D2643	Onlay - porcelain/ceramic - three surfaces .....	\$165.00
D2644	Onlay - porcelain/ceramic - four or more surfaces ..	\$175.00
D2650	Inlay - resin-based composite - one surface .....	\$85.00
D2651	Inlay - resin-based composite - two surfaces .....	\$95.00
D2652	Inlay - resin-based composite - three or more surfaces .....	\$115.00
D2662	Onlay - resin-based composite - two surfaces .....	\$110.00
D2663	Onlay - resin-based composite - three surfaces .....	\$120.00
D2664	Onlay - resin-based composite - four or more surfaces .....	\$145.00
D2710	Crown - resin-based composite (indirect) .....	\$40.00
D2712	Crown - 3/4 resin-based composite (indirect) .....	\$40.00
D2720	Crown - resin with high noble metal .....	\$160.00
D2721	Crown - resin with predominantly base metal .....	\$60.00
D2722	Crown - resin with noble metal .....	\$60.00
D2740	Crown - porcelain/ceramic .....	\$60.00
D2750	Crown - porcelain fused to high noble metal .....	\$160.00
D2751	Crown - porcelain fused to predominantly base metal .....	\$60.00
D2752	Crown - porcelain fused to noble metal .....	\$60.00
D2753	Crown - porcelain fused to titanium and titanium alloys .....	\$160.00
D2780	Crown - 3/4 cast high noble metal .....	\$160.00

D2781	Crown - 3/4 cast predominantly base metal .....	\$60.00
D2782	Crown - 3/4 cast noble metal .....	\$60.00
D2783	Crown - 3/4 porcelain/ceramic .....	\$195.00
D2790	Crown - full cast high noble metal .....	\$160.00
D2791	Crown - full cast predominantly base metal .....	\$60.00
D2792	Crown - full cast noble metal .....	\$60.00
D2794	Crown - titanium and titanium alloys .....	\$160.00
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 ( <i>anterior</i> ) .....	No Cost
D2928	Prefabricated porcelain/ceramic crown - permanent tooth .....	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - <i>anterior</i> .....	\$10.00
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth .....	No Cost
D2932	Prefabricated resin crown - <i>anterior primary tooth</i> .	\$10.00
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i> .....	\$10.00
D2940	Protective restoration .....	\$10.00
D2941	Interim therapeutic restoration - primary dentition .	\$10.00
D2949	Restorative foundation for an indirect restoration ..	\$10.00
D2950	Core buildup, including any pins when required .....	\$10.00
D2951	Pin retention - per tooth, in addition to restoration .	\$10.00
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i> .....	\$10.00
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> .....	\$10.00
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i> .....	\$10.00
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i> .....	\$10.00
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework. ....	\$12.00

D2980	Crown repair necessitated by restorative material failure .....	\$10.00
D2981	Inlay repair necessitated by restorative material failure .....	\$10.00
D2982	Onlay repair necessitated by restorative material failure .....	\$10.00
D2983	Veneer repair necessitated by restorative material failure .....	\$10.00
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to permanent molars</i> .....	\$5.00

**D3000-D3999 IV. ENDODONTICS**

D3110	Pulp cap - direct (excluding final restoration) .....	No Cost
D3120	Pulp cap - indirect (excluding final restoration) .....	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament .....	No Cost
D3221	Pulpal debridement, primary and permanent teeth	\$6.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development .....	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) .....	\$6.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) .....	\$6.00
D3310	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration) .....	\$30.00
D3320	<i>Root canal</i> - endodontic therapy, premolar tooth (excluding final restoration) .....	\$60.00
D3330	<i>Root canal</i> - endodontic therapy, molar tooth (excluding final restoration) .....	\$90.00
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 .....	\$45.00
D3347	Retreatment of previous root canal therapy - premolar .....	\$75.00
D3348	Retreatment of previous root canal therapy - molar .....	\$105.00

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 .....	\$50.00
D3421	Apicoectomy - premolar (first root) .....	\$50.00
D3425	Apicoectomy - molar (first root) .....	\$50.00
D3426	Apicoectomy (each additional root) .....	No Cost
D3430	Retrograde filling - per root .....	\$50.00
D3450	Root amputation - per root ( <i>Not covered in conjunction with Procedure D3920</i> ) .....	No Cost
D3471	Surgical repair of root resorption - anterior .....	\$50.00
D3472	Surgical repair of root resorption - premolar .....	\$50.00
D3473	Surgical repair of root resorption - molar .....	\$50.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	\$50.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar .....	\$50.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar ...	\$50.00
D3920	Hemisection (including any root removal), not including root canal therapy .....	No Cost
D3921	Decoronation or submergence of an erupted tooth	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 .....	\$75.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant .....	\$15.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth .....	\$15.00

D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant .....	\$75.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant .....	\$75.00
D4245	Apically positioned flap .....	\$75.00
D4249	Clinical crown lengthening - hard tissue .....	\$75.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant .....	\$150.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant .....	\$150.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant .....	\$195.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant .....	\$60.00
D4270	Pedicle soft tissue graft procedure .....	\$195.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area) .....	\$45.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft .....	\$195.00
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 .....	\$100.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i> .....	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i> .....	No Cost
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>1 D1110, D1120 or D4346 per 6 month period</i> .....	No Cost

D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i> .....	No Cost
D4910	Periodontal maintenance - <i>limited to 2 per calendar year (only covered after active therapy)</i> .....	No Cost
D4910	<i>Additional periodontal maintenance (beyond 2 per calendar year)</i> .....	\$55.00
D4921	Gingival irrigation with a medicinal agent - per quadrant .....	No Cost

**D5000-D5899 VI. PROSTHODONTICS (removable)**

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first three months after placement. You must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

- Interim dentures are limited to initial placement of interim partial denture/stayplate to replace extracted anterior tooth during healing.

D5110	Complete denture - maxillary .....	\$75.00
D5120	Complete denture - mandibular .....	\$75.00
D5130	Immediate denture - maxillary .....	\$90.00
D5140	Immediate denture - mandibular .....	\$90.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) .....	\$85.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) .....	\$85.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) .....	\$85.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) .....	\$85.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) .....	\$90.00



D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) .....	\$90.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) .....	\$90.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) .....	\$90.00
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 ...	\$135.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) .....	\$135.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth) .....	\$90.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth) .....	\$90.00
D5410	Adjust complete denture - maxillary .....	No Cost
D5411	Adjust complete denture - mandibular .....	No Cost
D5421	Adjust partial denture - maxillary .....	No Cost
D5422	Adjust partial denture - mandibular .....	No Cost
D5511	Repair broken complete denture base, mandibular .	\$15.00
D5512	Repair broken complete denture base, maxillary ....	\$15.00
D5520	Replace missing or broken teeth - complete denture (each tooth) .....	\$5.00
D5611	Repair resin partial denture base, mandibular .....	\$15.00
D5612	Repair resin partial denture base, maxillary .....	\$15.00
D5621	Repair cast partial framework, mandibular .....	\$15.00
D5622	Repair cast partial framework, maxillary .....	\$15.00
D5630	Repair or replace broken retentive/clasping materials - per tooth .....	\$15.00
D5640	Replace broken teeth - per tooth .....	\$5.00
D5650	Add tooth to existing partial denture .....	\$5.00
D5660	Add clasp to existing partial denture - per tooth ....	\$5.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary) .....	\$75.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular) .....	\$75.00

D5710	Rebase complete maxillary denture .....	\$30.00
D5711	Rebase complete mandibular denture .....	\$30.00
D5720	Rebase maxillary partial denture .....	\$30.00
D5721	Rebase mandibular partial denture .....	\$30.00
D5725	Rebase hybrid prosthesis .....	\$30.00
D5730	Reline complete maxillary denture (chairside) .....	\$15.00
D5731	Reline complete mandibular denture (chairside) ...	\$15.00
D5740	Reline maxillary partial denture (chairside) .....	\$15.00
D5741	Reline mandibular partial denture (chairside) .....	\$15.00
D5750	Reline complete maxillary denture (laboratory) .....	\$30.00
D5751	Reline complete mandibular denture (laboratory) ..	\$30.00
D5760	Reline maxillary partial denture (laboratory) .....	\$30.00
D5761	Reline mandibular partial denture (laboratory) .....	\$30.00
D5765	Soft liner for complete or partial removable denture - indirect .....	\$30.00
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary .....	No Cost
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular ...	No Cost
D5850	Tissue conditioning, maxillary .....	No Cost
D5851	Tissue conditioning, mandibular .....	No Cost

**D5900-D5999                    VII. MAXILLOFACIAL PROSTHETICS - Not Covered**

**D6000-D6199                    VIII. IMPLANT SERVICES - Not Covered**

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

- *When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional \$100.00 per crown, beyond the 6th unit.*

- *Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.*

D6210	Pontic - cast high noble metal .....	\$160.00
D6211	Pontic - cast predominantly base metal .....	\$60.00
D6212	Pontic - cast noble metal .....	\$60.00
D6240	Pontic - porcelain fused to high noble metal .....	\$160.00
D6241	Pontic - porcelain fused to predominantly base metal .....	\$60.00

D6242	Pontic - porcelain fused to noble metal .....	\$60.00
D6243	Pontic - porcelain fused to titanium and titanium alloys .....	\$60.00
D6245	Pontic - porcelain/ceramic .....	\$195.00
D6250	Pontic - resin with high noble metal .....	\$160.00
D6251	Pontic - resin with predominantly base metal .....	\$60.00
D6252	Pontic - resin with noble metal .....	\$60.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces .....	\$150.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces .....	\$160.00
D6602	Retainer inlay - cast high noble metal, two surfaces .....	No Cost
D6603	Retainer inlay - cast high noble metal, three or more surfaces .....	No Cost
D6604	Retainer inlay - cast predominantly base metal, two surfaces .....	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces .....	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces .....	No Cost
D6607	Retainer inlay - cast noble metal, three or more surfaces .....	No Cost
D6608	Retainer onlay - porcelain/ceramic, two surfaces .....	\$150.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces .....	\$165.00
D6610	Retainer onlay - cast high noble metal, two surfaces .....	No Cost
D6611	Retainer onlay - cast high noble metal, three or more surfaces .....	No Cost
D6612	Retainer onlay - cast predominantly base metal, two surfaces .....	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces .....	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces .....	No Cost
D6615	Retainer onlay - cast noble metal, three or more surfaces .....	No Cost
D6720	Retainer crown - resin with high noble metal .....	\$160.00
D6721	Retainer crown - resin with predominantly base metal .....	\$60.00
D6722	Retainer crown - resin with noble metal .....	\$60.00
D6740	Retainer crown - porcelain/ceramic .....	\$195.00

D6750	Retainer crown - porcelain fused to high noble metal .....	\$160.00
D6751	Retainer crown - porcelain fused to predominantly base metal .....	\$60.00
D6752	Retainer crown - porcelain fused to noble metal ....	\$60.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys .....	\$160.00
D6780	Retainer crown - 3/4 cast high noble metal .....	\$160.00
D6781	Retainer crown - 3/4 cast predominantly base metal .....	\$60.00
D6782	Retainer crown - 3/4 cast noble metal .....	\$60.00
D6783	Retainer crown - 3/4 porcelain/ceramic .....	\$195.00
D6784	Retainer crown - 3/4 titanium and titanium alloys ..	\$160.00
D6790	Retainer crown - full cast high noble metal .....	\$160.00
D6791	Retainer crown - full cast predominantly base metal .....	\$60.00
D6792	Retainer crown - full cast noble metal .....	\$60.00
D6930	Re-cement or re-bond fixed partial denture .....	No Cost
D6940	Stress breaker .....	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure .....	\$15.00

**D7000-D7999                    X. ORAL AND MAXILLOFACIAL SURGERY**

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

*- Extractions solely for orthodontic purposes are not covered.*

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 .....	No Cost
D7230	Removal of impacted tooth - partially bony .....	\$30.00
D7240	Removal of impacted tooth - completely bony .....	\$40.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications .....	\$40.00
D7250	Removal of residual tooth roots (cutting procedure) .....	No Cost
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only .....	No Cost

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
D7286	Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i> .....	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant .....	\$30.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant .....	\$30.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	\$40.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	\$40.00
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
D7471	Removal of lateral exostosis (maxilla or mandible) .	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
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**

- *The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of*

active treatment. Beyond 24 months, an additional monthly fee may apply.

- The Retention Copayment includes adjustments and/or office visits up to 24 months.

- In addition to the codes listed below, Pre and post orthodontic records may include any of the Intraoral, Extraoral or Bitewing codes listed in the Diagnostic section.

Pre and post orthodontic records include:

*The Benefit for pre-treatment records and diagnostic services includes: ..... \$300.00*

- D0210 Intraoral - comprehensive series of radiographic images
- D0251 Extraoral posterior dental radiographic image
- 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
- D0470 Diagnostic casts
- D0801 3D dental 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: .... \$120.00*

- D0210 Intraoral - comprehensive series of radiographic images
- D0470 Diagnostic casts
- D8010 Limited orthodontic treatment of the primary dentition ..... \$230.00
- D8020 Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19* ..... \$230.00
- D8030 Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19* ..... \$230.00

D8040	Limited orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> .....	\$430.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> .....	\$490.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> .....	\$490.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> .....	\$490.00
D8660	Pre-orthodontic treatment examination to monitor growth and development ( <i>Enrollee pays a \$25.00 fee if orthodontic treatment is not required or is declined by the Enrollee</i> ) .....	No Cost
D8670	Periodic orthodontic treatment visit ( <i>Charge per month for 24 months</i> ) .....	\$40.00
D8680	Orthodontic retention (removal of appliances, construction and placement of <i>removable</i> retainers) .....	No Cost
D8681	Removable orthodontic retainer adjustment .....	No Cost
D8999	Unspecified orthodontic procedure, by report - <i>includes treatment planning session</i> .....	\$200.00

**D9000-D9999                      XII. ADJUNCTIVE GENERAL SERVICES**

D9110	Palliative treatment of dental pain - per visit .....	\$5.00
D9211	Regional block anesthesia .....	No Cost
D9212	Trigeminal division block anesthesia .....	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures .....	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia .....	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes .....	\$83.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment .....	\$83.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes .....	\$83.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment ..	\$83.00
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 ....	\$5.00
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 .....	\$10.00
D9944	Occlusal guard - hard appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 24 months</i> .....	\$95.00
D9945	Occlusal guard - soft appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 24 months</i> .....	\$95.00
D9946	Occlusal guard - hard appliance, partial arch - <i>limited to 1 D9944, D9945 or D9946 in 24 months</i> .	\$95.00
D9951	Occlusal adjustment, limited .....	\$20.00
D9952	Occlusal adjustment, complete .....	\$40.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - <i>limited to one bleaching tray and gel for two weeks of self-treatment</i> .....	\$125.00
D9986	Missed appointment - <i>without 24 hour notice</i> .....	\$10.00
D9987	Canceled appointment - <i>without 24 hour notice</i> ....	\$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.

If services for a listed procedure are performed by the Contract Dentist, You pay the specified Copayment. Listed procedures which require a Dentist to provide Specialized Services, and are referred by the Contract Dentist, must be authorized by Us. You pay the Copayment specified for such services.

## SCHEDULE B

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

### Limitations and Exclusions of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*. (*Frequency limitations on diagnostic and preventive procedures do not apply when services are needed more frequently due to medical necessity as determined by the Contract Dentist*).
2. If You accept a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, You may be charged an additional \$100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Us, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's standard fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.

6. 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 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.

## 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), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. The replacement of lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Procedures, appliances or restorations if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
8. Consultations for non-covered Benefits.
9. Dental services received from any dental facility other than the Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for Emergency Services as described in the Evidence of Coverage.
10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

11. Prescription drugs.
12. Dental expenses incurred in connection with any dental or orthodontic procedure started before Your eligibility with the DeltaCare USA Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
13. Lost, stolen or broken orthodontic appliances.
14. Changes in orthodontic treatment necessitated by accident of any kind.
15. Myofunctional and parafunctional appliances and/or therapies.
16. Composite or ceramic brackets, lingual adaptation of orthodontic bands.
17. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
18. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.
19. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

## Non-Discrimination Disclosure

### Discrimination is Against the Law

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

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

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

if such denial or limitation results in discriminating against a transgender individual.

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

Delta Dental  
PO Box 997330  
Sacramento, CA 95899-7330  
1-866-530-9675  
deltadentalins.com

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

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

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

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

- qualified interpreters
- information written in other languages

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



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

¿Puede leer este documento? Si no, podemos encontrar a alguien que lo ayude a leerlo. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 1-800-422-4234 (servicio de retransmisión TTY deben llamar al 711). (Spanish)

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

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa lib्रेng tulong, pakitawagan ang 1-800-422-4234 (TTY: 711). (Tagalog)

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

이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수 있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-800-422-4234 (TTY: 711)번으로 연락하십시오. (Korean)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարո՞ղ եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 1-800-422-4234 (TTY: 711): (Armenian)

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

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

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-800-422-4234 (телетайп: 711). (Russian)

क्या आप इस दस्तावेज़ को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी सहायता करने हेतु किसी की व्यवस्था कर सकते हैं। आप इस दस्तावेज़ को अपनी भाषा में लिखा हुआ भी प्राप्त कर सकते हैं। निशुल्क सहायता के लिए, कृपया यहाँ कॉल करें 1-800-422-4234 (TTY: 711)। (Hindi)

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ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-800-422-4234 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-800-422-4234 (TTY: 711). (Hmong)

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