

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Combined Evidence of Coverage and Disclosure Form

California State University Enhanced Benefit - CAM35

Provided by:

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

Administered by:

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023
844-519-8751

deltadentalins.com

EVIDENCE OF COVERAGE DISCLOSURE FORM

DeltaCare USA Dental HMO Program

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

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

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

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

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

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a Contract Dentist may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Customer Service at 844-519-8751 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

The telephone number where you may obtain information about Benefits is 844-519-8751

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Definitions

As used in this booklet:

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

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

Contract means the agreement between DeltaCare USA/Delta Dental and California State University (CSU).

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 Benefit 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.

Domestic Partner means a person who, together with the Eligible Employee, has affirmed a domestic partnership through an Affidavit of Domestic Partnership filled with the applicant.

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

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

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

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

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

Open Enrollment Period means the annual timeframe when employees choose and/or change their health (dental) plans for the upcoming year.

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

Preauthorization means the process by which DeltaCare USA/ 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 judgement 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 DeltaCare USA/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 DeltaCare USA/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 of 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

New employees who are eligible must enroll themselves and Eligible Dependents within either sixty (60) days of employment or a permitting event or during Open Enrollment. New dependents should be enrolled as soon as they become dependents, and they will then immediately be covered for dental benefits on the first of the month following enrollment or attainment of dependent status if enrollment documents are received in a timely manner.

All eligible active employees who are appointed half-time or more for more than six months and who complete the enrollment process determined by the CSU Trustees are eligible for this Dental Care Program. Employees in certain academic year classifications may also be eligible if appointed for at least (6) weighted teaching units for at least one semester or two or more consecutive quarter terms. Retirees who are eligible to enroll as determined by the CSU Trustees are also eligible for this Dental Care Program.

Enrolled under the Enhanced Plan

Physicians (Unit 1)
CSUEU (Units 2, 5, 7 and 9)
CMA Operating Engineers (Unit 10)
Faculty (Unit 3)
Academic Support (Unit 4)
Skilled Crafts (Unit 6)
Management Personnel Plan (M80)
Executives (M89)
Confidential employees (C99)
FERP Participants
Retiree Voluntary Enhanced
Public Safety (Unit 8)

If you are on an approved leave of absence, you will continue to be covered if you make applicable payments directly to DeltaCare USA/Delta Dental.

Retiree Voluntary Enhanced Plan

Retirees can elect the Basic plan at no cost or they now have the option to purchase the voluntary enhanced plan. They can make this choice at retirement or during the plans open enrollment. New retirees will automatically enroll with the basic coverage unless they

confirm they want the voluntary enhanced plan. To enroll in the voluntary enhanced plan, Retirees need to Contact CalPERS at (888) 225-7377 or visit csuretirees.calstate.edu. To keep the Basic Plan, no action is required. Retirees and all eligible dependents will be enrolled in the same plan.

Uniformed Services Employment and Re-employment Rights Act (USERRA) of 1994

You can continue coverage for up to 24 months, if you take a leave governed by the Uniformed Services Employment and Re-employment Rights Act of 1994. If you make this election, you must submit any Premiums necessary, which may include administrative costs, to your employer. If you do not continue your coverage during a military leave, upon your return, it will be reinstated at the same Benefit level you received before your leave and consistent with CSU military leave policy.

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

Eligible Dependents become eligible on:

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

Eligible Dependents include:

- 1) spouse (unless legally separated or divorced) or Domestic Partner (until such partnership is terminated by either or both parties);
- 2) children from birth until the end of the month in which the child reaches age 26.

Children include recognized natural children, stepchildren, adopted children and children of a Domestic Partner. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 60 days after the date of birth for coverage to continue beyond 60 days. Legally adopted children (other than newborns) are eligible from and after the moment the child is placed in the physical custody of the Eligible Employee for adoption.

A dependent child may continue eligibility if:

- 1) he or she is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that began prior to reaching the limiting age of 26, and continues thereafter;

- 2) he or she is chiefly dependent on you for support; and
- 3) proof of dependent's disability certified by a physician 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.

Dependent coverage is also extended to any child who is recognized under a Qualified Medical Child Support Order (QMCSO).

Employees or retirees may not enroll in more than one state-sponsored plan at the same time. An employee or retiree who is also a family member of an employee or retiree may not be enrolled as both an employee or retiree and a family member.

Dependents in active military service are not eligible. Medicare eligibility shall not affect the eligibility of an Eligible Employee or an Eligible Dependent.

Prepayment Fees/Premiums

This Program requires premium to be paid to DeltaCare USA/Delta Dental by CSU. 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.

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. 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 844-519-8751. 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. Per

the effective date in your membership packet, you may obtain dental services. To make an appointment simply call you Contract Dentist's facility and identify yourself as a DentalCare USA Enrollee. Initial appointments should be scheduled within two to three 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 844-519-8751.

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 DELTACARE USA/ 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 (a) a partial or full denture for which final impressions have been taken, and (b) 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 844-519-8751 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 you 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 844-519-8751 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 DeltaCare USA/Delta Dental's Customer Service department at 844-519-8751. DeltaCare USA/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. DeltaCare USA/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 DeltaCare USA/Delta Dental with information about special features of their office, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact DeltaCare USA/Delta Dental's Customer Service department at 844-519-8751.

Benefits, Limitations and Exclusions

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

Copayments and Other Charges

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

Emergency Services

If Emergency Services are needed, you should contact your Contract Dentist whenever possible. If you are a new Enrollee needing Emergency Services, but do not have an assigned Contract Dentist yet, contact DeltaCare USA/Delta Dental's Customer Service

department at 844-519-8751 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 \$50.00 per emergency 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 DeltaCare USA/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 a 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 Orthodontist 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. DeltaCare USA/Delta Dental may also request that you obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of

receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact DeltaCare USA/Delta Dental's Customer Service department at 844-519-8751 or write to DeltaCare USA/Delta Dental.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by DeltaCare USA/Delta Dental. DeltaCare USA/Delta Dental will authorize a second opinion by an Out-of-Network provider if an appropriately qualified Contract Dentist is not available. DeltaCare USA/Delta Dental will only pay for a second opinion which DeltaCare USA/Delta Dental has approved or authorized. You will be sent a written notification should DeltaCare USA/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. For information refer to *Enrollee Complaint Procedures*.

Claims for Reimbursement

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

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. By statute, the DeltaCare USA provider contract contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by DeltaCare USA/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 DeltaCare USA/Delta Dental at the toll-free telephone number shown on the back cover of this booklet.

Processing Policies

DeltaCare USA/Delta Dental's dental care guidelines explain to its Contract Dentists what services are covered under the dental Contract. Contract Dentists will use their professional judgement 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 DeltaCare USA/Delta Dental for a determination of whether the proposed treatment is a covered benefit. DeltaCare USA/Delta Dental will also determine whether the proposed treatment requires treatment by a specialist. An Enrollee may contact DeltaCare USA/Delta Dental's Customer Service department at 844-519-8751 for information regarding DeltaCare USA/Delta Dental's dental care guidelines.

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, with the exception of any dental plan sponsored by the State of California (e.g. CalHR). Employees or their dependents covered by the CSU Dental Plan and a non-state sponsored dental plan by any carrier, including Delta, may coordinate benefits under both plans. 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 DeltaCare USA/Delta Dental and DeltaCare USA/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. DeltaCare USA/Delta Dental must, 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. DeltaCare USA/Delta Dental will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as DeltaCare USA/Delta Dental chooses, the amount of any Benefits paid by DeltaCare USA/Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

DeltaCare USA/Delta Dental shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of DeltaCare USA/Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call DeltaCare USA/Delta Dental's Customer Service department at 844-519-8751, 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 DeltaCare USA/Delta Dental within 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, DeltaCare USA/Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 5 calendar days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgement 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, DeltaCare USA/Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the complaint within three days.

If you have completed DeltaCare USA/Delta Dental's grievance process, or you have been involved in DeltaCare USA/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 **844-519-8751** 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: Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Any dispute arising out of or relating to this Contract or this dental health care program, including any disagreement with a claim determination made by DeltaCare USA/Delta Dental after exhaustion of the procedures outlined above, or any complaint regarding the quality of dental services performed by a Contract Dentist, Contract Orthodontist or Contract Specialist, which is not resolved within a reasonable period of time by authorized representatives of DeltaCare USA/Delta Dental and California State University, shall be brought to the attention of the Chief Executive Officer (or designated representative) of DeltaCare USA/Delta Dental and the Chief Business Officer (or designee) of California State University for joint resolution. At the request of either party, California State University shall provide a forum for discussion of the disputed item(s), at which time the designated, authorized representatives of California State University shall be available to assist in the resolution by providing advice to both parties regarding California State University contracting policies and procedures. If resolution of the dispute through these means is pursued without success, either party may seek resolution employing whatever remedies exist in law or equity beyond this Contract.

Public Policy Participation by Enrollees

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

Renewal and Termination of Benefits

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

Cancellation of Enrollment

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

- 1) Immediately upon loss of eligibility as described in this Evidence of Coverage.
- 2) Upon 15 days written notice if the premiums are not paid by or on behalf of the Enrollee on the date due. However, the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium; or
- 3) Upon 30 days written notice if:
 - a) the Contract is terminated or not renewed;
 - b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of this Program upon payment of all delinquent charges.
 - c) an Enrollee engages in conduct detrimental to safe operations and the delivery of services while a Contract Dentist's facility;
 - d) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this 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.

If you believe the enrollment has been cancelled or not renewed because of your health status or requirements for health care services, or that of your dependent(s), you may request a review by the Director of the California Department of Managed Health Care of the State of California. Please refer to *Enrollee Complaint Procedure* on pages 9-11.

Optional Continuation of Coverage (COBRA)

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) 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 or your Dependents may be entitled to continue coverage under this program, *at the Qualified Beneficiary’s expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section are shown below.

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 or termination of domestic partnership;
- Event 4. your dependents' loss of dependent status under the plan, and
- Event 5. as to your dependents only, your entitlement to Medicare.

You means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

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 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.

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 the filing, it is considered a Qualifying Event. If you are the retiree, and you have lost coverage because of this Qualifying Event, you may choose to continue coverage until your death. Your dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following your 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, 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 occurs:

- 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 DeltaCare USA/Delta Dental 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 program; or
- 6) entitlement to Medicare.

Once continued coverage ends, it cannot be reinstated.

Organ and Tissue Donation

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

SCHEDULE A

Description of Benefits and Copayments

The benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions and governing administrative policies of the program. Please refer to *Schedules B, C and F* for further clarification of benefits. Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology (“CDT”), CDT-2020 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>
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 - complete 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	Bitewing - two radiographic images.....	No Cost
D0273	Bitewing – three radiographic images.....	No Cost
D0274	Bitewing - four radiographic images - <i>limited to 1 series every 6 months</i>	No Cost
D0330	Panoramic radiographic image.....	No Cost
D0419	Assessment of salivary flow by measurement - <i>1 every 12 months</i>	No Cost
D0460	Pulp vitality tests.....	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - <i>1 every 3 years</i>	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 3 years</i>	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 3 years</i>	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
D1120	Prophylaxis <i>cleaning</i> - child - 2 D1110, D1120 or D4346 per calendar year.....	No Cost
D1206	Topical application of fluoride varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i>	No Cost
D1208	Topical application of fluoride - excluding varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i>	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars to age 14</i>	No Cost
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - <i>limited to permanent molars to age 14</i>	No Cost

D1353	Sealant repair - per tooth - <i>limited to permanent molars to age 14</i>	No Cost
D1354	Interim caries arresting medicament application - per tooth - <i>child to age 19; 1 per 6 month period</i>	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 - <i>child to age 9</i>	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 or involving incisal angle (anterior).....	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2510	Inlay - metallic - one surface ²	No Cost

D2520	Inlay - metallic - two surfaces ²	No Cost
D2530	Inlay - metallic - three or more surfaces ²	No Cost
D2543	Onlay - metallic - three surfaces ²	No Cost
D2544	Onlay - metallic - four or more surfaces ²	No Cost
D2710	Crown - resin-based composite (indirect)	No Cost
D2712	Crown - 3/4 resin-based composite (indirect)	No Cost
D2720	Crown - resin with high noble metal ^{2, 4}	No Cost
D2721	Crown - resin with predominantly base metal ⁴	No Cost
D2722	Crown - resin with noble metal ⁴	No Cost
D2740	Crown - porcelain/ceramic ⁴	No Cost
D2750	Crown - porcelain fused to high noble metal ^{2, 4}	No Cost
D2751	Crown - porcelain fused to predominantly base metal ⁴	No Cost
D2752	Crown - porcelain fused to noble metal ⁴	No Cost
D2753	Crown - porcelain fused to titanium and titanium alloys.....	No Cost
D2780	Crown - 3/4 cast high noble metal ²	No Cost
D2781	Crown - 3/4 cast predominantly base metal.....	No Cost
D2782	Crown - 3/4 cast noble metal.....	No Cost
D2790	Crown - full cast high noble metal ²	No Cost
D2791	Crown - full cast predominantly base metal.....	No Cost
D2792	Crown - full cast noble metal.....	No Cost
D2794	Crown - titanium and titanium alloys ²	No Cost
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
D2930	Prefabricated stainless steel crown - primary tooth.	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth.....	No Cost
D2940	Protective restoration.....	No Cost
D2941	Interim therapeutic restoration - primary detention.	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 - <i>includes canal preparation</i> ²	No Cost

D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> ²	No Cost
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	No Cost
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to permanent to molars to age 14</i>	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
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.....	No Cost
D3310	<i>Root canal</i> - endodontic therapy, anterior tooth excluding final restoration)	No Cost
D3320	<i>Root canal</i> - endodontic therapy, premolar tooth excluding final restoration)	No Cost
D3330	<i>Root canal</i> - endodontic therapy, molar tooth excluding final restoration)	No Cost
D3346	Retreatment of previous root canal therapy - anterior	No Cost
D3347	Retreatment of previous root canal therapy - premolar	No Cost
D3348	Retreatment of previous root canal therapy - molar	No Cost
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) (<i>to age 14</i>).....	No Cost
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) (<i>to age 14</i>)	No Cost
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) (<i>to age 14</i>).....	No Cost
D3410	Apicoectomy - anterior.....	No Cost
D3421	Apicoectomy - premolar (first root).....	No Cost

D3425	Apicoectomy – molar (first root).....	No Cost
D3426	Apicoectomy (each additional root).....	No Cost
D3427	Periradicular surgery without apicoectomy.....	No Cost
D3430	Retrograde filling - per root.....	No Cost
D3450	Root amputation, per root - <i>not covered in conjunction with a hemisection</i>	No Cost

D4000-D4999 V. PERIODONTICS

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	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 planning - four or more contiguous teeth or tooth bounded spaces per quadrant.....	No Cost
D4241	Gingival flap procedure, including root planning - 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	No Cost
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
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>2 D1110, D1120 or D4346 per calendar year</i>	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a	No Cost

subsequent visit - *limited to 1 treatment in any 12 consecutive months*.....

- D4910 Periodontal maintenance - *limited to 2 treatments each 12 month period*..... No Cost
- D4921 Gingival irrigation - per quadrant No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- D5110 Complete denture - maxillary No Cost
- D5120 Complete denture - mandibular No Cost
- D5130 Immediate denture - maxillary..... No Cost
- D5140 Immediate denture - mandibular..... No Cost
- D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)..... No Cost
- D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)..... No Cost
- D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)..... No Cost
- D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)..... No Cost
- D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)..... No Cost
- D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)..... No Cost
- D5223 Immediate maxillary partial denture -cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)..... No Cost
- D5224 Immediate mandibular partial denture -cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)..... No Cost
- 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.. No Cost
- D5512 Repair broken complete denture base, maxillary..... No Cost
- D5520 Replace missing or broken teeth - complete denture (each 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 broken teeth - per tooth	No Cost
D5650	Add tooth to existing partial denture	No Cost
D5660	Add clasp to existing partial denture - per tooth.....	No Cost
D5710	Rebase complete maxillary denture	No Cost
D5711	Rebase complete mandibular denture	No Cost
D5720	Rebase maxillary partial denture	No Cost
D5721	Rebase mandibular partial denture.....	No Cost
D5730	Reline complete maxillary denture (chairside).....	No Cost
D5731	Reline complete mandibular denture (chairside)	No Cost
D5740	Reline maxillary partial denture (chairside)	No Cost
D5741	Reline mandibular partial denture (chairside).....	No Cost
D5750	Reline complete maxillary denture (laboratory).....	No Cost
D5751	Reline complete mandibular denture (laboratory)	No Cost
D5760	Reline maxillary partial denture (laboratory)	No Cost
D5761	Reline mandibular partial denture (laboratory).....	No Cost
D5820	Interim partial denture (maxillary) - <i>limited to initial placement of interim partial denture / stayplate to replace extracted anterior teeth during healing</i>	No Cost
D5821	Interim partial denture (mandibular) - <i>limited to initial placement of interim partial denture / stayplate to replace extracted anterior teeth during healing</i>	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])

D6210	Pontic - cast high noble metal ²	No Cost
D6211	Pontic - cast predominantly base metal.....	No Cost
D6212	Pontic - cast noble metal.....	No Cost
D6240	Pontic - porcelain fused to high noble metal ^{2, 4}	No Cost
D6241	Pontic - porcelain fused predominantly base metal ⁴	No Cost

D6242	Pontic - porcelain fused to noble metal ⁴	No Cost
D6243	Pontic - porcelain fused to titanium and titanium alloys	No Cost
D6250	Pontic - resin with high noble metal ^{2, 4}	No Cost
D6251	Pontic - resin with predominantly base metal ⁴	No Cost
D6252	Pontic - resin with noble metal ⁴	No Cost
D6602	Retainer inlay - cast high noble metal, two surfaces ²	No Cost
D6603	Retainer inlay - cast high noble metal, three or more surfaces ²	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
D6611	Retainer onlay - cast high noble metal, three or more surfaces	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	No Cost
D6615	Retainer onlay - cast noble metal, three or more surfaces	No Cost
D6720	Retainer crown - resin with high noble metal ^{2, 4}	No Cost
D6721	Retainer crown - resin with predominantly base metal ⁴	No Cost
D6722	Retainer crown - resin with noble metal ⁴	No Cost
D6750	Retainer crown - porcelain fused to high noble metal ^{2, 4}	No Cost
D6751	Retainer crown - porcelain fused predominantly base metal ⁴	No Cost
D6752	Retainer crown - porcelain fused to noble metal ⁴	No Cost
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	No Cost
D6780	Retainer crown - 3/4 cast high noble metal ²	No Cost
D6781	Retainer crown - 3/4 cast predominantly base metal	No Cost
D6782	Retainer crown - 3/4 cast noble metal	No Cost
D6784	Retainer crown - 3/4 titanium and titanium alloys	No Cost
D6790	Retainer crown - full cast high noble metal	No Cost
D6791	Retainer crown - full cast predominantly base metal	No Cost
D6792	Retainer crown - full cast noble metal	No Cost
D6930	Re-cement o re-bond fixed partial denture	No Cost

D6940 Stress breaker..... No Cost

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY
- Includes preoperative and postoperative evaluations and treatment under 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..... No Cost

D7230 Removal of impacted tooth - partially bony No Cost

D7240 Removal of impacted tooth - completely bony..... No Cost

D7241 Removal of impacted tooth - completely bony,
with unusual surgical complications..... No Cost

D7250 Removal of residual tooth roots (cutting
procedure)..... No Cost

D7251 Coronectomy - intentional partial tooth removal No Cost

D7285 Incisional biopsy of oral tissue - hard (bone, tooth)
- does not include pathology laboratory procedures 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

D7450 Removal of benign odontogenic cyst or tumor -
lesion diameter up to 1.25 cm..... No Cost

D7471 Removal of lateral exostosis (maxilla or mandible)... 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

D7960 Frenulectomy - also known as frenectomy or
frenotomy - separate procedure not incidental to
another procedure No Cost

D8000-D8999 XI. ORTHODONTICS

D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19¹</i>	\$1,400.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19¹</i>	\$1,400.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>dependent adult children to age 26</i>	\$1,400.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adult employees and spouses</i>	\$1,600.00
D8660	Pre-orthodontic treatment examination to monitor growth and development - <i>not to be charged with any other consultation procedure(s)</i> ³	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) ⁵	No Cost
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - <i>includes the START-UP FEE, which includes initial examination, diagnosis, consultation and initial banding</i>	\$350.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure.....	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
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment - <i>for extractions only and only when medically necessary</i>	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	No Cost

D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9951	Occlusal adjustment, limited.....	No Cost
D9952	Occlusal adjustment, complete	No Cost
D9986	Missed appointment - <i>without 24 hour notice</i>	\$5.00
D9987	Canceled appointment - <i>without 24 hour notice</i>	\$5.00
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

FOOTNOTES

1. *Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 "Start-up fee." Beyond 24 months of active treatment, an additional monthly fee of \$25.00 applies.*
2. *Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the Enrollee at the additional laboratory cost of the high noble metal. This applies to crowns (including titanium crowns), bridges, indirectly fabricated posts and cores, inlays and onlays.*
3. *In the event comprehensive orthodontic treatment is not required or is declined by the Enrollee, a fee of \$25.00 will apply. The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.*
4. *Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$75.00.*
5. *Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee of \$25.00 applies.*

SCHEDULE B

Limitations of Benefits

1. Prophylaxis is limited to two treatments in a calendar year (includes periodontal maintenance).
2. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any three year period from initial placement.
3. Partial dentures are not to be replaced within any three year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
4. Crown(s) and bridges are not to be replaced within any three year period from initial placement.
5. Denture relines are limited to one per denture during any 12 consecutive months.
6. Periodontal scaling and root planing are limited to four quadrants during any 12 consecutive month period.
7. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period.
8. Bitewing x-rays are limited to not more than one series of four films in any six month period.
9. Full mouth x-rays are limited to one set every 24 consecutive months.
10. Sealant benefits 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 up to age nine and second molars up to age 14. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its applications.

11. General anesthesia and the services of a special anesthesiologist are limited to extractions only and only when medically necessary.
12. Accidental injury, except as noted in the Accident Injury Rider. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

Exclusion of Benefits

1. Cosmetic dental care.
2. Dental conditions arising out of and due to Enrollee's employment for which Workers' Compensation is paid. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision, except as provided in Section 1373(a) of the California Health and Safety Code.
3. Dental services performed in a hospital and related hospital fees.
4. Treatment of fractures and dislocations.
5. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures).
6. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
7. Any service that is not specifically listed as a covered expense.
8. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress.
9. Congenital malformations (e.g. congenitally missing teeth, supernumerary).
10. Cysts and malignancies, except as noted under *Schedule A, Description of Benefits and Copayments*.
11. Dispensing of drugs not normally supplied in a dental facility.
12. Cases in which, in the professional judgement of the attending Dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
13. Dental services received from any dental facility other than the assigned dental facility, unless expressly authorized in writing by Delta Dental or as cited under *Emergency Services*.
14. Prophylactic removal of impactions (asymptomatic, nonpathological).
15. "Specialist consultations" for noncovered benefits.

16. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
17. Crown lengthening procedures.
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.

Orthodontic Limitations

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

1. Orthodontic treatment must be provided by a Contract Orthodontist.
2. Plan benefits cover 24 months of usual and customary orthodontic treatment.
3. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not Delta Dental will be responsible for payment of balance due for treatment provided after cancellation or termination. In such a case the Enrollee's payment shall be based on a maximum of \$2,300 for dependent children to age 23 and \$2,500 for adults. The amount will be pro-rated over the number of months to completion of the treatment and, will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the Contract Orthodontist. **Start-up fees are included in these amounts.**
4. Start-up fees cover the initial examination, diagnosis, consultation and the retention phase of treatment of up to two years maximum. This includes initial construction, placement and adjustments to retainers and office visits for a maximum period of two years.
5. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation have been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of \$25.00 in addition to diagnostic record fees.
6. Three (3) recementations or replacements of a bracket/band on the same tooth or a total of five (5) rebracketings/ rebandings on different teeth during the covered course of treatment is a benefit. If any additional recementations or replacements of

brackets/brands are performed, the Enrollee is responsible for the cost.

7. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the Enrollee's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the Contract Orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same Copayment amounts as for fixed appliance.
8. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Orthodontic Exclusions

1. Pre-, mid- and post-treatment records which include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances.
3. Retreatment of orthodontic cases.
4. Changes in treatment necessitated by accident of any kind, and/or lack of patient cooperation.
5. Surgical procedures incidental to orthodontic treatment.
6. Myofunctional therapy.
7. Surgical procedures related to cleft palate, micrognathia or macrognathia.
8. Treatment related to temporomandibular joint disturbances and/or hormonal imbalance.
9. Supplemental appliances not routinely utilized in typical Phase II orthodontics.
10. Treatment that extends more than 24 months from the point of banding dentition will be subject to a per office visit charge of \$25.00.
11. Restorative work caused by orthodontic treatment.
12. Phase I orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.
13. Extractions solely for the purpose of orthodontics.
14. Transfer after banding has been initiated.
15. Lingually placed direct banded appliances, brackets and arch wires (invisible braces).

SCHEDULE C

Governing Administrative Policies

Unlike medical care where the diagnosis dictates more specifically the method of treatment to be rendered, in dental care, the dentist and patient frequently consider various treatment plans.

The following guidelines are an integral part of the dental program and are consistent with the principles of accepted dental practice and the continued maintenance of good dental health.

In all cases in which the Enrollee selects a more expensive plan of treatment than is customarily provided, the more expensive treatment is considered optional. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the two plans of treatment plus any copayment of covered procedures.

Replacement of prosthetic appliances (crowns, bridges, partials and full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the three year limitation for replacement.

1. PARTIAL DENTURES

A removable cast metal partial denture is considered an adequate restoration. If the Enrollee selects another course of treatment, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and the optional treatment, plus any copayment for the covered benefit.

If an cast metal partial denture will restore the case, the Contract Dentist will apply the difference of the cost of such procedure toward a more complicated precision appliance which the Enrollee and dentist may choose to use. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and the optional treatment, plus any copayment for the covered benefit.

An acrylic partial denture is the covered benefits in cases involving extensive periodontal disease.

2. COMPLETE DENTURES

If, in the construction of a denture, the Enrollee and the Contract Dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Full upper and/or lower dentures are not to exceed one each in any five-year period. The Enrollee is entitled to a new upper or lower denture only if the existing denture is more than three years old and cannot be made satisfactory by either relining or repair.

3. FILLINGS AND CROWNS

Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

The DeltaCare USA program provides amalgam and resin restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional, and if provided, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

A restoration is a covered benefit only when required for restorative reasons (radiographic evidence of decay or missing tooth structure). Restorations placed for any other purposes including but not limited to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth, or the anticipation of future fractures, are not covered benefits.

Composite resin restorations in posterior teeth are considered optional treatment. If provided, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. An allowance will be made for an acrylic crown. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

A crown placed on a specific tooth is allowable only once in a three-year period,

A pulp cap is a benefit only on a permanent tooth with an open apex.

4. FIXED BRIDGES

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 Enrollee'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 dental treatment. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Fixed bridges are not a benefit when provided in connection with a partial denture on the same arch. If provided, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

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

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

dental treatment. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

5. RECONSTRUCTION

The DeltaCare USA program provides coverage for procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) are not covered benefits. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework is considered full mouth reconstruction and is not a benefit of the DeltaCare USA program. The program will allow for complete or partial denture(s).

6. SPECIALIZED TECHNIQUES

Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization, are all considered optional treatment. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

7. PREVENTIVE CONTROL PROGRAMS

Any part of a preventive or soft tissue management program, which is not a listed covered service on Schedule A.

8. STAYPLATES

Stayplates are only a benefit to replace extracted anterior teeth for adults during a healing period and as anterior space maintainers for children.

9. FRENECTOMY

The frenum can be excised when the tongue has limited mobility; or has a large diastema between teeth; or when the frenum interferes with a prosthetic appliance.

10. PEDODONTIA

Pedodontic referrals must be preauthorized by Delta Dental. Benefits for dependent children to age 19 are covered at 100% of the Specialist's fee less any applicable copayments for covered benefits to a maximum of \$500 per child in a calendar year.

11. CORRECTION OF OCCLUSION

Selective equilibration of the dentition or restorations, not to include treatment of full mouth occlusal dysfunction.

12. TREATMENT PLANNING

The objective of this Program is to see that all Enrollees are brought to a good level of oral health and that this level of oral health is maintained. To achieve this objective takes careful treatment planning. Priorities have been established on the following basis:

- a. Priority attention is given to those procedures that, if not done first, could have an immediate effect on the Enrollee's overall health.
- b. Priority is next given to work such as active dental decay and periodontal problems that would not have an immediate effect on the Enrollee's oral health.
- c. Priority is then given to replacement of missing teeth not causing a gross lack of function.

Exceptions are made to this treatment planning concept based on individual circumstances.

Accident Injury Benefit

Delta Dental shall pay or otherwise discharge 100% of the Contract Dentist's "filed fees" not to exceed the "Prevailing Fee" as determined by Delta Dental or of Fess Actually Charged, whichever is less, less any applicable Enrollee copayments, for the following dental accident benefits:

Services described in the Schedule of Benefits and Copayments, Schedule A, and in paragraph II of this Rider, Schedule F are subject to the following maximum, limitation and exclusions when provided for conditions caused directly and independently of all other causes, by external, violent and accidental means.

I. DEFINITIONS

For the purpose of this Rider, the following additional definitions shall apply:

- A. "Attending Dentist's Statement" means the standard form used to file a claim.
- B. "Delta Accident Benefits" means those dental services which are provided under the terms of this Rider for conditions caused directly and independently of all other causes, by external, violent and accidental means.
- C. "Fee Actually Charged" means the "filed fee" for a particular dental service or procedure which a Contract Dentist reports to Delta Dental on an Attending Dentist's Statement, less any portion of such fee which is discounted, waived, rebated or which the Dentist does not in good faith attempt to collect.
- D. "Prevailing Fee" means the fee for a Single Procedure which satisfies the majority of Dentists in California, as determined by Delta Dental.
- E. "Single Procedure" means a dental procedure listed on a separate line in Schedule A and in paragraph II of this Rider, Schedule F.
- F. The term "filed fee" as used in this Rider shall have the following meaning:
"Filed Fee" means the Contract Dentist's fees on file with Delta Dental.

II. DENTAL ACCIDENT BENEFITS

For the purpose of this Rider, the following additional benefits shall apply:

- A. Intra-oral grafting
- B. Reimplantation
- C. Splinting
- D. Stayplate

III. MAXIMUM

The program shall provide Dental Accident Benefits for an Eligible Person up to a maximum of \$1,600 per Enrollee per any 12 month period.

IV. LIMITATION

Dental Accident Benefits shall be limited to services provided to an Eligible Person within 180 days following the date of accident, and shall not include any services for conditions caused by an accident occurring prior to the Enrollee's eligibility date.

V. EXCLUSIONS

The following services are not Dental Accident Benefits:

- A. Services for injuries or conditions which are benefits provided to the eligible Enrollee through a medical carrier or are compensable under Workers' Compensation or Employers' Liability Laws; services which are provided to the Enrollee by any federal or state government agency or are provided in Section 1373 (a) of the California Health and Safety Code.
- B. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to: cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- C. Services for restoring or stabilizing tooth structure lost from wear, or for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion. Such services include but are not limited to: equilibration and periodontal splinting.

- D. Prosthodontic services or any Single Procedure started prior to the date the Enrollee became eligible for such services under this Contract.
- E. Prescribed drugs, pre-medication or analgesia.
- F. Experimental procedures.
- G. Prophylaxis.
- H. All hospital costs and any additional fees charged by the Dentist for the hospital treatment.
- I. Charges for general anesthesia.
- J. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
- K. Implants (materials implanted into or on bone or soft tissue), the removal of implants or procedures related to the placement or removal of implants.
- L. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.
- M. Replacement of existing restorations due to carious lesions.
- N. Orthodontic services (treatment of malalignment of teeth and/or jaws).

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

DeltaCare USA
PO Box 1803 Alpharetta, GA 30023-1803
844-519-8751
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:

- o qualified sign language interpreters
- o 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:

- o qualified interpreters
- o information written in other languages

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

Protect your oral health. Prevention is the key to avoiding tooth and gum problems. Brush and floss regularly, and visit the dentist for cleanings and exams. To learn more about prevention and avoiding dental problems, visit **deltadentalins.com**. You'll find oral health articles, videos and other tools and tips for caring for your teeth. Don't forget to sign up for *Grin!*, our free dental health e-magazine.

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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 844-519-8751 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ।
(Punjabi)

Դուք կարող եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կօգնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ զրոյան ձեր լեզվով: Անվճար օգնություն համար խնդրում ենք զանգահարել 844-519-8751 (TTY: 711): (Armenian)

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 844-519-8751 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសាបស្ចិមលោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 844-519-8751 (TTY: 711)។ (Cambodian)

צי קענט איר לייענען דעם דאזיקן דאָקומענט? אױב נישט, עמעצער דאָ קען אײַך העלפֿן אים צו לייענען. עס איז אײַך מעגלעך, אָז איר קענט באַקומען דעם דאזיקן דאָקומענט אין אײַער שפּראַך פֿאַר אומױסטע הילף קענט איר אַנקלײַנגען אָט די דאזיקע נומער:
(Yiddish) 711 האָט הערן נישט: 844-519-8751

Díísh yíníłta'go bííníghah? Doo bííníghahgóó éí nich'í' yídóółtahígíí nihee hółǫ́. Díí naaltsoos t'áá Diné bizaad k'éhjí' ályaago áłdó' nich'í' ádoolníłtgo bííghah. T'áá jíí'k'e shíká i'doolwoł nínízingo kojí' béésh holdíílnih 844-519-8751 (TTY: 711) (Navajo)

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

Toll Free
844-519-8751

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