DeltaCare® USA

Delta Dental Individual & Family
DeltaCare® USA Preferred Plan FLA70

Combined Policy and Disclosure Form

Provided by:
Delta Dental Insurance Company

Administered by:
Delta Dental Insurance Company

Delta Dental Insurance Company
provides Benefits as a Prepaid Limited Health Service Organization
as described in Part 1, Chapter 636 of Title 37 of the Florida Statutes

_____
Enrollee's Name

This Policy Contains a Copayment Provision.

deltadentalins.com

Policy/Disclosure Form ("Policy")

You must make an election for any eligible person You wish to cover under this Policy. Election must be made when You enroll or as described in the Eligibility Requirements provision. If an election is not made for an individual or dependent, such person will not be eligible under this Policy.

Your dental plan is underwritten and administered by Delta Dental Insurance Company ("Delta Dental"). This Policy discloses the terms and conditions of the individual DeltaCare® USA dental plan available in Florida. This Policy is issued in exchange for payment of the first installment of Premium and on the basis of the statements made on Your application. This Policy will remain in force unless otherwise terminated in accordance with its terms, until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where You live.

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

TEN (10)-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this Policy. If this Policy was solicited by deceptive advertising or negotiated by deceptive, misleading or untrue statements, or if You are not satisfied, You may return this Policy within ten (10) days after You received it. Mail or deliver it to Delta Dental Insurance Company. Any Premium paid will be refunded. This Policy will then be void from its start, and You will be responsible for the costs of any services rendered during the 10 day period if the Policy is returned.

This Policy is signed for Delta Dental Insurance Company, as of its Effective Date by:

Michael G. Hankinson, Esq.
President

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INTRODUCTION

We are pleased to welcome You to this individual DeltaCare USA dental plan. Our goal is to provide You with the highest quality dental care and to help You maintain good dental health. We encourage You not to wait until You have a problem to see the Dentist, but to see him or her on a regular basis.

Using This Policy

This Policy discloses the terms and conditions of Your coverage and is designed to help You make the most of Your dental plan. It will help You understand how the dental plan works and how to obtain dental care. Please read this Policy completely and carefully. Keep in mind that "You" and "Your" mean the Enrollees who are covered under this Policy. "We," "us" and "our" always refer to Delta Dental.

Contact Us

If You have any questions about Your coverage that are not answered here, please visit our website at deltadentalins.com or call our Customer Service Center at 888-282-9501

If You prefer to write to us with Your question(s), please mail Your inquiry to the following address:

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

Identification Number

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

DEFINITIONS

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

Authorization: the process by which Delta Dental determines if a procedure or treatment is a referable Benefit under Your plan.

Benefits: covered dental services provided under the terms of this Policy.

Calendar Year: the 12 months of the year from January 1 through December 31.

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

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

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

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

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

Effective Date: the original date this policy starts.

Eligible Dependent: a person who is a dependent of an Eligible Primary as described in this Policy.

Eligible Primary: a person who meets the conditions of eligibility in this Policy as described in the Eligibility Requirements provision.

Emergency Services: only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing Your health in serious jeopardy.

Enrollee: an Eligible Primary ("Primary Enrollee") or Eligible Dependent ("Dependent Enrollee") enrolled under this Policy to receive Benefits.

Optional: any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by You and is subject to the limitations and exclusions of this Policy.

Out-of-Network: treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits under the terms of this Policy.

Policy: this agreement between Delta Dental and the Primary Enrollee including any application and any Attachments. This Policy constitutes the entire agreement between the parties.

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

Policyholder: the Primary Enrollee who enrolls for coverage.

Premium: the amount payable as provided on the application or renewal notice.

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

Qualifying Status Change:

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

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

Specialist Services: services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics or pediatric dentistry. If there is not an available Contract Specialist in the service area, there are no Benefits for Specialist Services.

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

- as defined and as may be required to be treated as a Spouse by the laws of the state where this Policy is issued and delivered; or

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

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

ELIGIBILITY AND ENROLLMENT

A person may be covered under only one Delta Dental individual policy at a time. If an individual is enrolled to receive Benefits as a Primary Enrollee, Dependent Enrollee or another similar defined term under another Delta Dental individual policy, said individual is not eligible under this Policy.

Eligibility Requirements

An Eligible Primary is a person who lives inFlorida, who is not on active military duty and who is 18 years of age or older.

Primary Enrollees electing to enroll their eligible family members must enroll them at the time the Primary Enrollee enrolls, or

- within 90 days of the Primary Enrollees initial enrollment; or
- within 31 days of a Qualifying Status Change.

If Your dependents are covered, they will be eligible when You are or as soon as they become dependents.

- Dependents are the Primary Enrollee's Spouse; and
- Dependent children from birth to age 26.

- Children include natural children, stepchildren, foster children, adopted children, children placed for adoption, children of Spouse and children for which You have been appointed legal guardian. The dependents of Primary Enrollees are eligible to enroll on the same date that the Primary Enrollee, of whom they are a Dependent, becomes a Primary Enrollee. Later-acquired dependents become eligible as soon as they acquire dependent status. Newborn children, including a newborn child of a covered dependent child or a newborn child where a written agreement to adopt has been entered into prior to birth, are eligible from the moment of birth. Adopted children are eligible from the moment of placement in Your residence, or in the case of a newborn child, from the moment of birth, if You have entered into a written agreement to adopt the child prior to the birth of the child.
    - Notice of birth, adoption placement, foster home placement or other custodial placement of a child with employee must be received within 31 days of the birth or placement. If notice of birth or adoption is received within the 31 day notice period, no additional premiums are due during the notice period. If notice is received within 60 days of the birth or adoption placement instead of 31 days, coverage will be effective from the date of birth or placement, but You must pay any additional Premium from the date of birth or placement. Eligibility for a newborn child of covered dependent child terminates 18 months after the birth of the newborn.

- A dependent child is eligible 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;
  (2) he or she is chiefly dependent on the Primary Enrollee for support; and
  (3) proof of dependent child's disability is provided within 31 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. Enrollment will continue as long as the dependent relies on the Primary Enrollee for support because of a physically or mentally disabling injury, illness or condition that began before he or she reached the limiting age.

Dependents on active military duty are not eligible.

Minimum Enrollment Period

Enrollees in this Policy must enroll for a minimum of 12 months, unless You request, in writing, a shorter Policy period. If coverage is voluntarily discontinued, Enrollees may not re-apply during the 12 month period immediately following the voluntary termination.

Renewal

Delta Dental will provide 30 days advance written notice of any change in Premium at renewal.

The Primary Enrollee may keep this Policy in force by timely payment of the Premiums. However, Delta Dental may refuse renewal due to:

- non-payment of Premiums, subject to the "*Grace Period on Late Payments*" provision;
- fraud or material misrepresentation made by or with the knowledge of the Primary Enrollee or You applying for this coverage or filing a claim for Benefits;
- the Primary Enrollee failing to comply with material provisions of this Policy; or
- Delta Dental ceasing to renew all Policies issued on this form to residents of the service area where You live.

Except for non-payment of Premium, at least 45 day notice of any non-renewal action permitted by this clause will be mailed to the Primary Enrollee at the last address shown in Delta Dental's records. If Delta Dental fails to provide 45 days notice of our intent to terminate coverage, Your coverage will remain in effect until 45 days after notice is given or until the effective date of replacement coverage, whichever occurs first. However, no Benefits will be paid for expenses incurred during any period of time for which Premium has not been paid.

Termination of Coverage

You have the right to terminate coverage under this Policy by sending Delta Dental written notice of intent to terminate this Policy. Termination of this Policy and coverage for You and Your Dependent(s) will be effective on the last day of the month that we receive Your request.

A full refund of Premium is available if a written request for a refund is made within the first 10 days of the Effective Date.

You may keep this Policy in force by timely payment of the Premiums. However, Delta Dental may terminate coverage due to:

- Enrollee no longer eligible under the terms of this Policy (note termination in this case automatically occurs on the last day of the month in which You no longer meets eligibility requirements);
- non-payment of Premiums, subject to the "*Grace Period on Late Payments*" provision;
- fraud or material misrepresentation made by or with the knowledge of the Primary Enrollee or Enrollee applying for this coverage or filing a claim for Benefits; or
- Delta Dental ceasing to renew all Policies issued on this form to residents of the service area where You live.

If Your coverage is terminated, except for non-payment of Premium, we will send at least a 45-day advance written notice to You informing You of the reason(s) why coverage is terminated and the date that Your coverage will end. For treatment in progress, we will continue to provide Benefits less any applicable Copayment.

Reinstatement

This Policy may be reinstated with no break in coverage provided the full Premium due is received by us within 60 days of the date of the past due Premium. The reinstated Policy will have the same rights as before Your Policy lapsed, unless a change is made to Your Policy in connection with the reinstatement. These changes, if any, will be sent to You for You to attach to Your Policy.

OVERVIEW OF DENTAL BENEFITS

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

What is the DeltaCare USA plan?

The DeltaCare USA plan provides Benefits through a convenient network of Contract Dentists. These Dentists are screened to ensure that our standards of quality, access and safety are maintained. The network is composed of established dental professionals. When You visit Your assigned Contract Dentist, You pay only the applicable Copayment for Benefits. There are no deductibles, lifetime maximums or claim forms.

Benefits, Limitations and Exclusions

This plan provides the Benefits described in the Schedules that are a part of this Policy. Benefits are only available in the state of Florida. The services are performed as deemed appropriate by Your attending Contract Dentist.

Copayments and Other Charges

You are required to pay any Copayments listed in the Schedules attached to this Policy. Copayments are paid directly to the Dentist who provides treatment. Charges for broken appointments and visits after normal visiting hours are listed in the Schedules attached to this Policy.

In the event that we fail to pay a Contract Dentist, You will not be liable to that Dentist for any sums owed by us. If You have not received Authorization for treatment from an Out-of-Network Dentist, and we fail to pay that Out-of-

Network Dentist, You may be liable to that Dentist for the cost of services. For further clarification, see "*Emergency Services"* and "*Specialist Services*."

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

Delta Dental will provide Contract Dentists at convenient locations during the term of this Policy. To enroll in the Plan, You must select a Contract Dentist from the list of dental facilities provided with this Policy. Policyholder may request changes to the assigned Contract Dentist facility by directing a request to the Customer Service Center at 888-282-9501. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. The change must be requested prior to the 15th of the month to become effective on the first day of the following month.

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

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

All services which are Benefits will be rendered at the Contract Dentist facility assigned to You or a Contract Specialist upon referral by the Contract Dentist and authorized by Delta Dental. Delta Dental will have no obligation or liability with respect to services rendered by Out-of Network Dentists, with the exception of Emergency

Services. If there is not an available Contract Specialist in the service area, there are no Benefits for Specialist Services. A Contract Dentist may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services.

If Your assigned Contract Dentist facility terminates participation in the plan, that Contract Dentist facility will complete all treatment in progress as described above.

Emergency Services

The assigned Contract Dentist facility maintains a 24 hour Emergency Services system seven (7) days a week. If Emergency Services are needed, You should contact the Contract Dentist facility whenever possible. If You are unable to reach the Contract Dentist facility for Emergency Services, You should call the Customer Service Center at 888-282-9501 for assistance in obtaining urgent care. During non-business hours or if You require Emergency Services and are 35 miles or more from Your assigned Contract Dentist facility, You do not need to call for referral and may seek treatment from a Dentist other than at the assigned Contract Dentist facility. You are responsible for the Copayment(s) for any treatment received due to an emergency. Emergency dental care is limited to palliative treatment for the elimination of dental pain.

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 this maximum is exceeded, You are responsible for any charges for services by a Dentist other than Your Contract Dentist. Further treatment must be obtained from the assigned Contract Dentist facility.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics or pediatric dentistry must be: 1) referred by the assigned Contract Dentist; and 2) authorized by us. If there is not an available Contract Specialist in the service area, there are no Benefits for Specialist Services.

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

Claims for Reimbursement

Claims for covered Emergency Services should be sent to us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if You can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one (1) year of the treatment date. The address for claims submission is:

Claims Department
P.O. Box 1810
Alpharetta, GA 30023-1810

Processing Policies

The dental care guidelines for the DeltaCare USA Program explain to Contract Dentists what services are covered under this Policy. Contract Dentists will use their professional judgment to determine which services are appropriate for You. Services performed by the Contract Dentist that fall under the scope of Benefits of this Policy 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 888-282-9501 for information regarding the dental care guidelines for DeltaCare USA.

ENROLLEE COMPLAINT PROCEDURE

Delta Dental will provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial.

Informal Grievances

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 Center at 888-282-9501. A grievance is not considered formal until Delta Dental receives a written complaint.

Formal Grievances

Written complaints may be addressed to:

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

Written communication must include: 1) the name of the patient; 2) the name, address; telephone number and Your ID number ; and 3) the Dentist's name and facility location.

Within 10 business days of the receipt of any complaint, 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 Dentist 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 or will provide a written explanation if additional time is required to report on the complaint.

Appeal of Decision

A review of the decision will be undertaken if a written request for an appeal of the determination is made within 30 days of the date of the written determination. Delta Dental will undertake a full and fair review upon request. Delta Dental may require additional documents, as it deems necessary, in making such a review. Delta Dental will provide a written response to You within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If You believe You need further review of Your claim, You may contact the State of Florida Department of Financial Services. The State of Florida Department of Financial Services may be contacted at any time, concerning any complaint or request for assistance, by writing to 200 East Gaines St., Tallahassee, FL 32399-0322, or by calling the Office's toll-free consumer hotline: 1-877-693-5236.

PREMIUM PAYMENT RESPONSIBILITIES

Each Premium is to be paid on or before its due date. A due date is the day following the last day of the period for which the preceding Premium was paid. You may pay Your Premium by visiting our website at deltadentalins.com, or by mailing payment to the address below:

Delta Dental Insurance Company
P.O. Box 660138
Dallas, TX 75266-0138

Rate Guarantee

Your Premium rate is guaranteed for each Policy Year based upon the new Enrollee rates in force at the time of Your enrollment. The rate guarantee can be less than a Policy Year if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change.

No change in Premiums will become effective within a Policy Year unless Delta Dental's liability is changed by law or regulation. Such a change may include a state and/or federal mandated change or a new or increased tax, assessment or fee imposed on the amounts payable to, or by, Delta Dental under this Policy or any immediately preceding Policy between Delta Dental and You. Delta Dental would provide written notice to You, and this Policy will thereby be modified on the date set forth in the notice.

Grace Period on Late Payments

A grace period of 31 days will be granted for the payment of each Premium falling due after the first Premium. During this time, this Policy will continue in force. If Your coverage terminates for non-payment, You will be responsible for the cost of services rendered during the grace period.

Coverage will terminate at the end of the grace period unless we receive Your Premium before the end of these 31 days.

Extension of Benefits

Benefits will continue to be provided for dental services provided to a patient who is totally disabled when coverage ends if:

1) the Dentist recommends the services to the patient and the services began while the coverage was in effect;
2) the dental services to be performed by the dentist, if the dentist:
    a) prepared the abutment teeth for the completion of installation of prosthetic devices;
    b) made an impression;
    c) prepared the tooth for cast restoration; or
    d) opened the pulp chamber before the insurance ends and the device is installed or treatment was finished within 90 days after the termination of coverage;
3) the services are provided within 90 days after the patient's coverage ended, and the coverage did not end because the patient (or, in the case of a dependent child, the child's parent) voluntarily terminated coverage.

The extension of Benefits ends at the earlier of:

1) the end of the 90-day period in 3) above; or
2) the date the patient becomes covered under a succeeding policy.
   However, if coverage for the dental services described in this *Extension of Benefits* provision

are excluded by the succeeding policy through the use of an elimination period or limitations and the patient is not covered by the succeeding policy, the extension of Benefits does not terminate.

All contractual limitations, exclusions or reductions that would have applied to the specific dental services had this coverage not terminated apply during the extension of Benefits.

Conversion

Any Eligible Enrollee who has been continuously enrolled in this Program for at least 3 months immediately prior to termination is eligible for a conversion Contract providing Benefits similar to the terminated Contract. A person electing to convert to his or her own individual coverage must pay Premium to Delta Dental at individual rates established by Delta Dental. This provision will not apply if coverage is terminated due to (a) failure to pay any required Premium, (b) replacement of discontinued coverage within 31 days, (c) fraud or material misrepresentation in applying for or obtaining Benefits, (d) misuse of Benefits, (e) moving out of the DeltaCare service area or (f) uncooperative or abusive behavior toward the Contract Dentist's and/or Delta Dental's staff.

GENERAL PROVISIONS

Entire Contract; Changes

This Policy, including any application and Attachments, constitutes the entire contract of insurance. No change to this Policy will be valid until approved by our executive officer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Severability

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

Incontestability

After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for this Policy will be used to void this Policy or to deny a claim for loss incurred or disability commencing after the expiration of such 2-year period.

No claim for loss incurred or disability commencing after two (2) years from the date of issue of this Policy will be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed prior to the Effective Date of this Policy.

Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under this Policy, all statements made by You will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Policy unless it is contained in a written application. If any misstatement would materially affect the rates, we reserve the right to adjust the Premium to reflect Your actual circumstances at time of application or to terminate Your Policy.

Legal Actions

No action at law or in equity will be brought to recover on this Policy prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of this Policy. No action can be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

Conformity with Applicable Laws

All legal questions about this Policy will be governed by the state of Florida where this Policy was entered into and is to be performed. Any part of this Policy that conflicts with the laws of Florida or federal law is hereby amended to conform to the minimum requirements of such laws.

Third Party Administrator (“TPA”)

Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under this Policy. Any TPA providing such services or receiving such information will enter into a separate business associate agreement with Delta Dental

providing that the TPA will meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

Impossibility of Performance

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

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/she has individually, or as a member of any specific class of persons, been subjected to discrimination may file a complaint in writing to:

DeltaCare USA Customer Service
P.O. Box 1860
Alpharetta, GA 30023-1860

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as needed and deemed necessary by the attending 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 their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare® USA Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2026, procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association® ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	YOU PAY
D0100-D0999	**I. DIAGNOSTIC – (*When referable services are provided by a Contract Specialist, You pay 75% of that Dentist's "submitted fees."*) ***	
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 - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted.*	No Cost

CODE	DESCRIPTION	YOU PAY
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	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extra-oral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images - *limited to 1 series every 6 months*	No Cost
D0273	Bitewings - three radiographic images - *limited to 1 series every 6 months*	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted.*	No Cost
D0396	3D printing of a 3D dental surface scan	No Cost
D0419	Assessment of salivary flow by measurement - 1 every 12 months	No Cost
D0460	Pulp vitality tests	No Cost
D0461	Testing for cracked tooth	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report – *available only when performed in conjunction with a covered biopsy*	*No Cost*
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost

CODE	DESCRIPTION	YOU PAY
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 12 months*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 12 months*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 12 months*	No Cost
D0701	Panoramic radiographic image – image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral – occlusal radiographic image - image capture only	No Cost
D0707	Intraoral – periapical radiographic image - image capture only	No Cost
D0708	Intraoral – bitewing radiographic image - image capture only	No Cost
D0709	Intraoral – comprehensive series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$10.00

CODE	DESCRIPTION	YOU PAY

D1000-D1999 II. PREVENTIVE – (*When referable services are provided by a Contract Specialist, You pay 75% of that Dentist's "submitted fees."*) *

D1110	*Cleaning* - Prophylaxis - adult - *2 D1110, D1120 or D4346 per 12 month period*	$20.00
D1120	*Cleaning* - Prophylaxis - child - *2 D1110, D1120 or D4346 per 12 month period*	$20.00
D1206	Topical application of fluoride varnish - *child to age 19; 2 of D1206 or D1208 per 12 month period*	$20.00
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 2 of D1206 or D1208 per 12 month period*	$20.00
D1310	Nutritional counseling for control of dental disease	No Cost
D1320	Tobacco counseling for the control and prevention of oral disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$22.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$22.00
D1354	Application of caries arresting medicament - per tooth	$20.00
D1510	Space maintainer – fixed, unilateral – per quadrant	$85.00
D1516	Space maintainer – fixed – bilateral, maxillary	$85.00
D1517	Space maintainer – fixed – bilateral, mandibular	$85.00
D1520	Space maintainer - removable – unilateral – per quadrant	$85.00
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$10.00
D1553	Re-cement or re-bond bilateral space maintainer – per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer – per quadrant	$10.00

CODE	DESCRIPTION	YOU PAY
D1557	Removal of fixed bilateral space maintainer – maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer – mandibular	$10.00
D1575	Distal shoe space maintainer - fixed - unilateral – per quadrant *child to age 9*	$85.00

D2000-D2999 III. RESTORATIVE – (*When referable services are provided by a Contract Specialist, You pay 75% of that Dentist's "submitted fees."*) *

- *Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.*
- *Fillings are covered 1 per 24 month(s) per tooth, per surface. Replacement of an amalgam or resin restoration on the same tooth surface in less than two years by the same Dentist or by a Dentist at the same location is not chargeable to Delta Dental or You.*
- *Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.*

D2140	Amalgam - one surface, primary or permanent	$25.00
D2150	Amalgam - two surfaces, primary or permanent	$40.00
D2160	Amalgam - three surfaces, primary or permanent	$50.00
D2161	Amalgam - four or more surfaces, primary or permanent	$55.00
D2330	Resin-based composite - one surface, anterior	$65.00
D2331	Resin-based composite - two surfaces, anterior	$75.00
D2332	Resin-based composite - three surfaces, anterior	$85.00
D2335	Resin-based composite - four or more surfaces (anterior)	$115.00
D2390	Resin-based composite crown, anterior	$115.00
D2391	Resin-based composite - one surface, posterior	$70.00
D2392	Resin-based composite - two surfaces, posterior	$80.00
D2393	Resin-based composite - three surfaces, posterior	$115.00
D2394	Resin-based composite - four or more surfaces, posterior	$120.00
D2510	Inlay - metallic - one surface [1]	$260.00

CODE	DESCRIPTION	YOU PAY
D2520	Inlay - metallic - two surfaces [1]	$270.00
D2530	Inlay - metallic - three or more surfaces [1]	$280.00
D2542	Onlay - metallic - two surfaces [1]	$270.00
D2543	Onlay - metallic - three surfaces [1]	$290.00
D2544	Onlay - metallic - four or more surfaces [1]	$300.00
D2610	Inlay - porcelain/ceramic - one surface [2,4]	$350.00
D2620	Inlay - porcelain/ceramic - two surfaces [2,4]	$385.00
D2630	Inlay - porcelain/ceramic - three or more surfaces [2,4]	$405.00
D2642	Onlay - porcelain/ceramic - two surfaces [2,4]	$415.00
D2643	Onlay - porcelain/ceramic - three surfaces [2,4]	$415.00
D2644	Onlay - porcelain/ceramic - four or more surfaces [2,4]	$425.00
D2650	Inlay - resin-based composite - one surface [2]	$250.00
D2651	Inlay - resin-based composite - two surfaces [2]	$275.00
D2652	Inlay - resin-based composite - three or more surfaces [2]	$310.00
D2662	Onlay - resin-based composite - two surfaces [2]	$305.00
D2663	Onlay - resin-based composite - three surfaces [2]	$330.00
D2664	Onlay - resin-based composite - four or more surfaces [2]	$375.00
D2710	Crown - resin-based composite (indirect) [2]	$125.00
D2712	Crown – 3/4 resin-based composite (indirect) [2]	$125.00
D2720	Crown - resin with high noble metal [2]	$425.00
D2721	Crown - resin with predominantly base metal [2]	$325.00
D2722	Crown - resin with noble metal [2]	$425.00
D2740	Crown - porcelain/ceramic [2,4]	$495.00
D2750	Crown - porcelain fused to high noble metal [2,3,4]	$425.00
D2751	Crown - porcelain fused to predominantly base metal [2,3]	$325.00
D2752	Crown - porcelain fused to noble metal [2,3]	$425.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$425.00
D2780	Crown - 3/4 cast high noble metal	$425.00
D2781	Crown - 3/4 cast predominantly base metal	$325.00

CODE	DESCRIPTION	YOU PAY
D2782	Crown - 3/4 cast noble metal	$425.00
D2783	Crown - 3/4 porcelain/ceramic [2,4]	$495.00
D2790	Crown - full cast high noble metal	$425.00
D2791	Crown - full cast predominantly base metal	$325.00
D2792	Crown - full cast noble metal	$425.00
D2794	Crown - titanium and titanium alloys	$495.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$15.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$15.00
D2920	Re-cement or re-bond crown	$15.00
D2921	Reattachment of tooth fragment, incisal edge or cusp – *anterior*	$115.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth – *anterior*	$95.00
D2930	Prefabricated stainless steel crown - primary tooth	$55.00
D2931	Prefabricated stainless steel crown - permanent tooth	$55.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$95.00
D2933	Prefabricated stainless steel crown with resin window – *anterior primary tooth*	$95.00
D2940	Placement of interim direct restoration	$10.00
D2949	Restorative foundation for an indirect restoration	$85.00
D2950	Core buildup, including any pins when required	$85.00
D2951	Pin retention - per tooth, in addition to restoration	$30.00
D2952	Post and core in addition to crown, indirectly fabricated- *base metal post; includes canal preparation* [1]	$85.00
D2953	Each additional indirectly fabricated post - same tooth- *includes canal preparation* [1]	$50.00
D2954	Prefabricated post and core in addition to crown - *includes canal preparation*	$75.00
D2955	Post removal	$40.00
D2956	Removal of an indirect restoration on a natural tooth	No Cost

CODE	DESCRIPTION	YOU PAY
D2957	Each additional prefabricated post - same tooth - *includes canal preparation*	$45.00
D2971	Additional procedures to customize a crown to fit under an existing partial denture framwork.	$65.00
D2976	Band stabilization - per tooth - limited to 1 per tooth per lifetime	$50.00
D2980	Crown repair necessitated by restorative material failure	$50.00
D2981	Inlay repair necessitated by restorative material failure	$50.00
D2982	Onlay repair necessitated by restorative material failure	$50.00
D2983	Veneer repair necessitated by restorative material failure	$50.00
D2989	Excavation of a tooth resulting in the determination of non-restorability	No Cost
D2990	Resin infiltration of incipient smooth surface lesions – *limited to permanent through age 15*	$22.00

D3000-D3999 IV. ENDODONTICS – (*When referable services are provided by a Contract Specialist, You pay 75% of that Dentist's "submitted fees."*) *

- *With the exception of pulp caps, pulpotomies, pulpal debridements, and pulpal therapies with resorbable fillings, all endodontic procedures listed below are Benefits for permanent teeth only.*

D3110	Pulp cap - direct (excluding final restoration)	$10.00
D3120	Pulp cap - indirect (excluding final restoration)	$10.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$45.00
D3221	Pulpal debridement, primary and permanent teeth	$45.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$45.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$45.00

CODE	DESCRIPTION	YOU PAY
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$45.00
D3310	*Root canal* - endodontic therapy - anterior tooth (excluding final restoration)	$240.00
D3320	*Root canal* - endodontic therapy – premolar tooth (excluding final restoration)	$350.00
D3330	*Root canal* - endodontic therapy – molar tooth (excluding final restoration)	$400.00
D3331	Treatment of root canal obstruction; non-surgical access	$240.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$240.00
D3346	Retreatment of previous root canal therapy - anterior	$500.00
D3347	Retreatment of previous root canal therapy - premolar	$600.00
D3348	Retreatment of previous root canal therapy - molar	$725.00
D3410	Apicoectomy - anterior	$470.00
D3421	Apicoectomy - premolar (first root)	$535.00
D3425	Apicoectomy - molar (first root)	$580.00
D3426	Apicoectomy (each additional root)	$115.00
D3430	Retrograde filling - per root	$65.00
D3450	Root amputation - per root	$315.00
D3471	Surgical repair of root resorption – anterior	$470.00
D3472	Surgical repair of root resorption – premolar	$470.00
D3473	Surgical repair of root resorption – molar	$470.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$470.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root Resorption – premolar	$470.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root Resorption – molar	$470.00
D3911	Intraorifice barrier	No Cost

CODE	DESCRIPTION	YOU PAY
D3920	Hemisection (including any root removal), not including root canal therapy	$95.00
D3921	Decoronation of submergence of an erupted tooth	$40.00

D4000-D4999 ..... V. PERIODONTICS – (*When referable services are provided by a Contract Specialist, You pay 75% of that Dentist's submitted fees.*) *

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$260.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$150.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$350.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$280.00
D4249	Clinical crown lengthening - hard tissue	$280.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$650.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$520.00
D4270	Pedicle soft tissue graft procedure	$290.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$95.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$300.00

CODE	DESCRIPTION	YOU PAY
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	$300.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant- *limited to once per quadrant during any 24 consecutive months*	$80.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant- *limited to once per quadrant during any 24 consecutive months*	$64.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *2 D1110, D1120 or D4346 per 12 month period*	$20.00
D4355	Full mouth debridement to enable a comprehensive periodontal oral evaluation and diagnosis on subsequent visit - *limited to 1 treatment per lifetime*	$80.00
D4910	Periodontal maintenance - *limited to 2 treatment each 12 month period*	$65.00
D4921	Gingival irrigation with 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 Participating Provider's facility where the denture was originally delivered.*
- *Relines and tissue conditioning are limited to 1 per denture during any 6 consecutive months.*
- *Rebases are limited to 1 per denture in a 24-month period.*
- *Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.*

D5110	Complete denture - maxillary	$495.00
D5120	Complete denture - mandibular	$495.00

CODE	DESCRIPTION	YOU PAY
D5130	Immediate denture - maxillary	$550.00
D5140	Immediate denture - mandibular	$550.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$400.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$400.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases(including any retentive/clasping materials, rests, and teeth)	$565.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests, and teeth)	$565.00
D5221	Immediate maxillary partial denture – resin base (including any retentive/clasping materials, rests, and teeth)	$400.00
D5222	Immediate mandibular partial denture – resin base (including any retentive/clasping materials, rests, and teeth)	$400.00
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any retentive/clasping materials, rests, and teeth)	$565.00
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any retentive/clasping materials, rests, and teeth)	$565.00
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests and teeth)	$700.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests and teeth)	$700.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$400.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$400.00

CODE	DESCRIPTION	YOU PAY
D5410	Adjust complete denture - maxillary	$24.00
D5411	Adjust complete denture - mandibular	$24.00
D5421	Adjust partial denture - maxillary	$24.00
D5422	Adjust partial denture - mandibular	$24.00
D5520	Replace missing or broken teeth - complete denture- per tooth	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$75.00
D5640	Replace missing or broken teeth – partial denture - per tooth	$45.00
D5650	Add tooth to existing partial denture-per tooth	$60.00
D5660	Add clasp to existing partial denture - per tooth	$75.00
D5710	Rebase complete maxillary denture	$180.00
D5711	Rebase complete mandibular denture	$180.00
D5720	Rebase maxillary partial denture	$180.00
D5721	Rebase mandibular partial denture	$180.00
D5725	Rebase hybrid prosthesis	$180.00
D5730	Reline complete maxillary denture (chairside)	$75.00
D5731	Reline complete mandibular denture (chairside)	$75.00
D5740	Reline maxillary partial denture (chairside)	$75.00
D5741	Reline mandibular partial denture (chairside)	$75.00
D5750	Reline complete maxillary denture (laboratory)	$150.00
D5751	Reline complete mandibular denture (laboratory)	$150.00
D5760	Reline maxillary partial denture (laboratory)	$150.00
D5761	Reline mandibular partial denture (laboratory)	$150.00
D5765	Soft line for complete or partial removable denture – indirect	$150.00
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - *limited to 1 in any 12 consecutive months*	$175.00
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - *limited to 1 in any 12 consecutive months*	$175.00
D5850	Tissue conditioning, maxillary	$40.00

CODE	DESCRIPTION	YOU PAY
D5851	Tissue conditioning, mandibular	$40.00

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)

- 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	$425.00
D6211	Pontic - cast predominantly base metal	$325.00
D6212	Pontic - cast noble metal	$425.00
D6240	Pontic - porcelain fused to high noble metal [2,4]	$425.00
D6241	Pontic - porcelain fused to predominantly base metal [2]	$325.00
D6242	Pontic - porcelain fused to noble metal [2]	$425.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$425.00
D6245	Pontic - porcelain/ceramic [2,4]	$495.00
D6250	Pontic - resin with high noble metal [2]	$425.00
D6251	Pontic - resin with predominantly base metal [2]	$325.00
D6252	Pontic - resin with noble metal [2]	$425.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces [2,4]	$385.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces [2,4]	$405.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$370.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$380.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$270.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$280.00
D6606	Retainer inlay - cast noble metal, two surfaces	$370.00

CODE	DESCRIPTION	YOU PAY
D6607	Retainer inlay - cast noble metal, three or more surfaces	$380.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces [2,4]	$395.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces [2,4]	$415.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$370.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$390.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$270.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$290.00
D6614	Retainer onlay - cast noble metal, two surfaces	$370.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$390.00
D6720	Retainer crown - resin with high noble metal [2]	$425.00
D6721	Retainer crown - resin with predominantly base metal [2]	$325.00
D6722	Retainer crown - resin with noble metal [2]	$425.00
D6740	Retainer crown - porcelain/ceramic [2,4]	$495.00
D6750	Retainer crown - porcelain fused to high noble metal [2,3,4]	$425.00
D6751	Retainer crown - porcelain fused to predominantly base metal [2,3]	$325.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys [2,3,4]	$425.00
D6752	Retainer crown - porcelain fused to noble metal [2,3]	$425.00
D6780	Retainer crown - 3/4 cast high noble metal	$425.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$325.00
D6782	Retainer crown - 3/4 cast noble metal	$425.00
D6783	Retainer crown - 3/4 porcelain/ceramic [2,4]	$495.00
D6784	Retainer crown – ¾ - titanium and titanium alloys	$425.00
D6790	Retainer crown - full cast high noble metal	$425.00

CODE	DESCRIPTION	YOU PAY
D6791	Retainer crown - full cast predominantly base metal	$325.00
D6792	Retainer crown - full cast noble metal	$425.00
D6930	Re-cement or re-bond fixed partial denture	$30.00
D6940	Stress breaker	$50.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$75.00

D7000-D7999....X. ORAL AND MAXILLOFACIAL SURGERY – (*When referable services are provided by a Contract Specialist, You pay 75% of that Dentist's "submitted fees."*) *

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

D7111	Extraction, coronal remnants - primary tooth	$30.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$40.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning oftooth, and including elevation of mucoperiosteal flap if indicated	$70.00
D7220	Removal of impacted tooth - soft tissue	$100.00
D7230	Removal of impacted tooth - partially bony	$190.00
D7240	Removal of impacted tooth - completely bony	$210.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$230.00
D7250	Removal of residual tooth roots (cutting procedure)	$75.00
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	$230.00
D7259	Nerve dissection – *available only when performed in conjunction with the removal of an impacted tooth, complete bony, with unusual surgical complications*	*No Cost*
D7284	Excisional biopsy of minor salivary glands - does not include pathology laboratory procedures	$100.00
D7286	Incisional biopsy of oral tissue - soft *- does not include pathology laboratory procedures*	$100.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$150.00

CODE	DESCRIPTION	YOU PAY
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$150.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$200.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$200.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$150.00
D7472	Removal of torus palatinus	$150.00
D7473	Removal of torus mandibularis	$150.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$35.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$55.00
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	$160.00

D8000-D8999 XI. ORTHODONTICS

***If a copayment dollar amount is not listed, You pay 75% of the Contract Orthodontist's "submitted fees."*

- *You must continue to be eligible during active treatment. Orthodontic treatment covers up to 24 months of active treatment, excluding the services listed for D8999 (Start-up fee) and D8680 (Orthodontic retention). Beyond 24 months, an additional monthly fee, not to exceed 75% of the Contract Orthodontist's "submitted fees" per month applies.*
- *Orthodontic retention includes adjustments and/or office visits up to 24 months.*
- *You are responsible for any incurred orthodontic diagnostic record fees.*

CODE	DESCRIPTION	YOU PAY
D8010	Limited orthodontic treatment of the primary dentition	**
D8020	Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	**
D8030	Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19*	**
D8040	Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children.*	**
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	**
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	**
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	**
D8091	Comprehensive orthodontic treatment with orthognathic surgery	**
D8660	Pre-orthodontic treatment examination to monitor growth and development [5] - *1 per 6 month period when performed by the same Contract Dentist or office*	No Cost
D8670	Periodic orthodontic treatment visit – *included in comprehensive orthodontic case fee*	No Cost
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery - *included in comprehensive orthodontic case fee*	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	**
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes START-UP FEES (including initial examination, diagnosis, consultation and initial banding)*	$200.00

CODE	DESCRIPTION	YOU PAY

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES – (*When referable services are provided by a Contract Specialist, the You pay 75% of that Dentist's "submitted fees."*) *

D9110	Palliative treatment of dental pain -per visit	$35.00
D9210	Local anesthesia not in conjunction with operative or surgical procedures	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
D9310	Consultation - diagnostic service provided by Dentist or physician other than requesting Dentist or physician	$70.00
D9311	Consultation with 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	$40.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	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
D9941	Fabrication of athletic mouthguard	$110.00
D9951	Occlusal adjustment, limited	$40.00
D9952	Occlusal adjustment, complete	$90.00

CODE	DESCRIPTION	YOU PAY
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice*	$50.00
D9987	Canceled appointment - *without 24 hour notice*	$50.00
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

Teledentistry services provided by a Dentist other than Your Contract Dentist are considered Out-of-Network and may result in an out-of-pocket cost to You.

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

FOOTNOTES

** If services for a listed procedure are performed by the assigned Contract Dentist, You pay the specified Copayment. Listed, referable procedures that are not available in the contract facility or that require a Dentist to provide Specialist Services may be provided by a contracted oral surgeon, endodontist, periodontist or pediatric Dentist at 75% of the Contract Specialist's "submitted fees." Specialist Services are only available upon referral by the assigned Contract Dentist or authorized by Delta Dental.*

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

2 *Porcelain/ceramic crown, pontic and fixed bridge retainer on molars are considered a material upgrade with a maximum additional charge to You of $150.00 per unit.*

3 *For a covered porcelain-fused-to-metal crown, a porcelain margin is considered a material upgrade with a maximum additional charge to You of $75.00 per unit.*

4 *Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Refer to Schedule B for Limitations and Exclusions for additional information.*

5 *In the event orthodontic treatment is not required or is declined by You, a fee of $85.00 will apply. You are also responsible for any incurred orthodontic diagnostic record fees.*

SCHEDULE B

Limitations and Exclusions of Benefits
Delta Dental Individual & Family
DeltaCare® USA Basic Plan FLA70

Limitations of Benefits

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

2. Fillings (amalgams and composites) are Benefits for the removal of decay, for minor repairs of tooth structure or to replace a lost or failing restoration.

3. The placement of a crown, inlay or onlay is a Benefit when there is insufficient tooth structure to support a filling.

4. Placement of interim direct restoration is included in the fee for all covered Endodontic procedures (D3220-D3950) when done on the same date by the same Dentist/dental office.

5. The fee for removal of an indirect restoration is included in the fee for any subsequent restorative procedure.

6. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. Contract Dentists may offer services that utilize brand or trade names at an additional fee. You must be offered the Plan Benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If You choose the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through

specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Contact the Customer Service department at 888-282-9501 if you have questions regarding the additional fee or name brand services.

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

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

   b. Either of the following:

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

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

8. Coverage for the placement of a fixed partial denture (bridge) requires that:

   a. No cantilevered posterior pontic (prosthetic tooth) be included; and

      - The tooth/teeth to be replaced in the arch is a permanent tooth, which cannot be replaced by adding another tooth to an existing removable partial denture; or

      - The new bridge would replace an existing, non-functional bridge; or

- Each abutment tooth to be crowned meets Limitation #3.
- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

9. Benefits for retained primary teeth are limited to services applicable to a primary tooth.

10. Excision of the frenum is a Benefit only when it causes limited mobility of the tongue, a large diastema between teeth or it interferes with a prosthetic appliance.

11. Nerve dissection is included in the fee for the removal of an impacted tooth, complete bony, with unusual surgical complications, as part of that extraction procedure. Otherwise, nerve dissection is not a benefit.

12. Local anesthesia and regional/or trigeminal block anesthesia are not separately payable procedures.

13. Benefits provided by a Contracted pediatric Dentist are available at 75 percent of the Contract Specialist's "submitted fees." Referral by the assigned Contract Dentist is required before services are received.

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

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

16. Limited orthodontic treatment (any dentition) and comprehensive orthodontic treatment (any dentition) are part of comprehensive orthodontic treatment with orthognathic surgery.

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

18. The Copayment is payable to the Contract Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, You change to another Contract Orthodontist to continue orthodontic treatment, You:

    a. will not be entitled to a refund of any amounts previously paid, and

    b. will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.

19. The cost to You receiving orthodontic treatment if Your coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's submitted fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. You make payment directly to the Contract Orthodontist as arranged.

    Exception to extend covered orthodontics Benefits to a cancelled or terminated Policy is as follows:

    a. For 60 days after the date coverage terminates if the Contract Orthodontist has agreed to or is receiving monthly payments; or

    b. Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Contract Orthodontist has agreed to accept or is receiving payments on a quarterly basis.

20. Fabrication of athletic mouthguard is limited to once every 24 months for patients 18 and younger.

21. Teledentistry services provided by a Dentist other than Your Contract Dentist are considered Out-of-Network and may result in an out-of-pocket cost to You.

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

23. Image Limitations:

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

Exclusions of Benefits

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

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

3. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges) and orthodontic appliances.

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

5. Dental expenses incurred in connection with any dental procedure 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.

6. Prescription and over-the-counter drugs.

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

8. Dental services received from any dental facility other than the assigned Contract Dentist, including the services of an out-of-network dental specialist, unless expressly authorized by Us or as cited under *Emergency Services* as described in the Policy.

9. Consultations or other diagnostic services for non-covered Benefits.

10. Duplication of images.

11. Implant supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.

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

13. 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.

14. Administration of dermal fillers.

15. Administration of neuromodulators.

16. Procedures, appliances or restorations if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), with the exception of procedures D9951 and D9952 as shown on *Schedule A, Description of Benefits and Copayments*.

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

18. 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.

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

20. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.

21. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

22. Accidental injury. Accidental injury is defined as damage to the hard and soft tissue 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.

23. Myofunctional and parafunctional appliances and/or therapies.

24. Pre-, mid- and post-treatment records for orthodontia including cephalometric images, tracings, photographs and study models.

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

26. Any part of a preventive or soft tissue management program which is not a listed covered service on *Schedule A, Description of Benefits and Copayment*.

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

28. Services or supplies for sleep apnea.

29. Photobiomodulation therapy.

HIPAA Notice of Privacy Practices

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our privacy practices reflect applicable federal law as well as state law. The privacy laws of a particular state or other federal laws might impose a stricter privacy standard. If these stricter laws apply and are not superseded by federal preemption rules under the Employee Retirement Income Security Act of 1974, the Plans will comply with the stricter law.

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

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

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

PERMITTED USES AND DISCLOSURES OF YOUR PHI

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

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

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

Permitted uses and disclosures without an authorization

We are permitted to disclose your PHI upon your request, or to your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human

Services to investigate or determine our compliance with the law, and when otherwise required by law. We may disclose your PHI without your prior authorization in response to the following:

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

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

Disclosures made with your authorization

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

YOUR RIGHTS REGARDING PHI

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

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

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

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

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

You have the right to request or receive confidential communications from us by alternative means or at a different address.
You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.
You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes

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

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

You have the right to be notified following a breach of unsecured protected health information.
We will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

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

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

CONTACTS

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

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330

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

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

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

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

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

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

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

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

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 المساعدة المجانية اتصل بـ - 1-866-530-9675 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-866-530-9675 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n'est pas le cas, nous pouvons faire en sorte que quelqu'un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l'assistance gratuitement, veuillez appeler le 1-866-530-9675 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-866-530-9675 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-866-530-9675 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-866-530-9675 (TTY: 711). (Italian)

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

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 1-866-530-9675 (Schreibtelefon: 711). (German)

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

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

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

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

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

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

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

צי קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט,עמעצער דאָ קען איִך העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אַז איר קענט באַקומען דעם דאָזיקן דאָקומענט אין אייִער שפּראַך. פֿאַר אומזיסטע הילף קענט איר אָנרופֿן אַט די דאָזיקע נומער: 1-866-530-9675 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'į' yídóołtahígíí nihee hóló. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaagoałdó' nich'į' ádoolnį́łgo bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojį' béésh holdíílnih 1-866-530-9675 (TTY: 711) (Navajo)

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.

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.

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).

deltadentalins.com

ENROLLEE NOTICES

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

Federal Notices:

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

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

- **Notice of Non-Discrimination:** We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. If you believe we have failed to provide these services or discriminated in another way on the basis of race, color,

national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

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

State Notices:

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

- **CA Grievance Process:** This notice describes our procedure for processing and resolving enrollee grievances and gives the address and phone number to make a complaint. Californians are encouraged to read this notice when they first enroll and annually thereafter.
- **CA Timely Access to Care:** California law requires health plans to provide timely access to care. This law sets limits on how long enrollees must wait to get appointments and telephone assistance.

- **CA Tissue and Organ Donations:** This notice informs subscribers of the societal benefits of organ donation and the methods they can use to become organ and/or tissue donors. California regulations require every health plan to provide this information upon enrollment and annually thereafter.

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- **CA Annual Deductible and OOP Max Accrual Balances:** California law requires health plans to provide enrollees with up-to-date accrual balances towards their annual deductible and out-of-pocket maximum for every month benefits were used until the accrual balances are met. Enrollees have the right to request their most up-to-date accrual balance from the health plan at any time.
- **CA Request Confidential Communications:** This notice informs subscribers of methods of contacting the plan when there is a need or desire to provide and alternative address to received protected health information. Users may also choose to use the "Request for Confidential Communication" form when submitting such request.

For questions concerning the notices, please contact us at 866-530-9675**.** You may also write to us at:

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330

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