DELTA DENTAL®

Delta Dental Individual & Family™
Delta Dental PPO™
Premium Plan for Families

Combined Policy and Disclosure Form

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when You elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to Your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. **YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT.** Participating providers have agreed to accept discounted payments for services with no additional billing to You other than coinsurance, copayment, and deductible amounts. You may obtain further information about the providers who have contracted with Your insurance plan by consulting Your insurer's website or contacting Your insurer or agent directly.

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Enrollee's Name

This Policy Contains a Deductible Provision

Provided by:
Delta Dental Insurance Company
deltadentalins.com

Policy

You must elect to enroll any eligible person You wish to cover under this Policy. 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"). Delta Dental will pay for covered dental services as set forth in this Policy. 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. **This Policy is Renewable Subject to Delta Dental Consent.** Please refer to the Renewable Subject to Delta Dental Consent provision in this Policy for terms of renewability. All periods will begin and end at 12:01 A.M., Standard Time, where You live.

IMPORTANT NOTICE

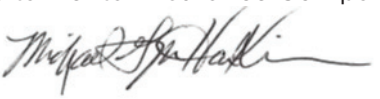
READ YOUR POLICY AND ATTACHMENTS CAREFULLY TEN (10) DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this Policy. Carefully check the application and write to Delta Dental Insurance Company, P.O. Box 1809, Alpharetta, GA 30023-1809 if this Policy was solicited by deceptive advertising or negotiated by deceptive, misleading or untrue statements. If You are not satisfied that the information is correct You may return this Policy within 10 days after You receive it. Mail or deliver it to Delta Dental. The application is a part of the Policy and the Policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete. Any Premium paid will be refunded. This Policy will then be void from its start.

This Policy is issued and delivered in the state of Florida and is governed by its laws. If You move and no longer reside in the State of Florida, please contact our Customer Service Center at 888-282-8784.

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

Delta Dental Insurance Company



Michael G. Hankinson, Esq.

President

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INTRODUCTION

Delta Dental's 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 one on a regular basis.

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

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 and/or Policyholder 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 number at 888-282-8784.

Our website allows You to find Delta Dental Providers, complete a customer service form and register for online services. Our Customer Service Center, 888-282-8784 provides access to our automated information line and customer service representatives to present inquiries, to provide assistance in resolving complaints, and speak to a Customer Service representative for assistance.

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

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Identification Number

Please provide Your identification ("ID") number to Your Provider whenever You receive dental services. Your ID number should be included on all claims submitted for payment. ID cards are not required, but if You wish to have one 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.

Accepted Fee: the amount the attending Provider agrees to accept as payment in full for services rendered.

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.

Claim Form: the standard form used to file a claim or request a Pre-Treatment Estimate.

Deductible: a dollar amount that You must satisfy for certain covered services before We begin paying for Benefits.

Delta Dental PPO Contracted Fee ("PPO Provider's Contracted Fee"): the fee for each Single Procedure that a PPO Provider has contractually agreed to accept as payment in full for covered services.

Delta Dental PPO Provider ("PPO Provider"): a Provider who contracts with Us or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental PPO Contracted Fee as payment in full for services provided under a PPO plan. A PPO Provider also agrees to comply with Our administrative guidelines.

Delta Dental Premier® Contracted Fee ("Premier Provider's Contracted Fee"): the fee for each Single Procedure that a Premier Provider has contractually agreed to accept as payment in full for covered services.

Delta Dental Premier Provider ("Premier Provider"): a Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental Premier Contracted Fee as payment in full for services provided under a plan. A Premier Provider also agrees to comply with Our administrative guidelines.

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: residents of Florida who are legally able to enter into an agreement.

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

Enrollee Pays: an Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Delta Dental Pays" on the claims statement when a claim is processed.

Maximum Contract Allowance: the reimbursement under the Enrollee's benefit plan against which We calculate its payment and the financial obligation for the Enrollee. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by a PPO Provider is the lesser of the Submitted Fee or the PPO Provider's Contracted Fee; or
- by a Premier Provider is the lesser of the Submitted Fee or the PPO Provider's Contracted Fee for a PPO Provider in the same geographic area; or
- by a Non-Delta Dental Provider is the lesser of the Submitted Fee or the PPO Provider's Contracted Fee for a PPO Provider in the same geographic area.

Non-Delta Dental Provider: a Provider who is not a PPO Provider or a Premier Provider and who is not contractually bound to abide by Our administrative guidelines.

Policy: this agreement between Us and the Policyholder including any Attachments. This Policy constitutes the entire agreement between the parties.

Policy Benefit Level: the percentage of the Maximum Contract Allowance that We will pay.

Policyholder: the Primary Enrollee who enrolls for coverage.

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

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

Pre-Treatment Estimate: an estimation of the allowable Benefits under this Policy for the services proposed, assuming the person is an eligible Enrollee.

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

Provider: a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

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, children in Enrollees custodial care);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee moves);
- court order requiring dependent coverage; or

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

Spouse: a person required to be treated as a Spouse of the Policyholder under Florida law.

Submitted Fee: the amount that the Provider bills and enters on a Claim Form for a specific procedure.

Teledentistry: the delivery of dental services through telehealth or telecommunications that may include the use of real-time encounter; live video (synchronous) or information stored and forwarded for subsequent review (asynchronous).

Waiting Period: the amount of time an Enrollee must be enrolled under this Policy for specific services to be covered as described in the Attachments which are part of this Policy. No exceptions or credits are given for prior coverage provided under any plan.

ELIGIBILITY AND ENROLLMENT

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

Eligibility Requirements

Policyholders electing to enroll Eligible Dependents must enroll them at the time of initial enrollment, within 90 days of initial enrollment or within 31 days of a Qualifying Status Change.

- Dependents are the Policyholder's Spouse and dependent children from birth to age 26.

- Your unmarried dependent children from age 26 to the end of calendar year which the child reaches the age of 30 if the child:
    - does not have a dependent of his or her own;
    - is a resident of the state of Florida or a full-time or part-time student; and
    - is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.
- Children include natural children, stepchildren, foster children, adopted children, children placed for adoption, children of Spouse, children in Your custodial care and children for which You have been appointed legal guardian.

  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 whether or not the the agreement is enforceable, 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 Enrollee 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 the Enrollee must pay any additional Premium from the date of birth or placement.

- Children who reach the limiting age may be eligible if:

  (1) they are incapable of self-support because of an intellectual or physical disability; and

  (2) they are chiefly dependent on the Policyholder or Spouse for support.

Dependents on active military duty are not eligible.

Renewable Subject to Delta Dental Consent

We will provide 45 days advance written notice of any change in Premium at renewal.

The Policyholder may keep this Policy in force for 12 months by timely payment of the Premiums. However, We 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 Policyholder or Dependent Enrollee when applying for this coverage or filing a claim for Benefits;
- the Policyholder failing to comply with material provisions of this Policy;
- the Policyholder moving out of the state in which this Policy was issued; or
- We cease to renew all Policies issued on this form to residents of the state where You live. At least 45 days' notice of any non-renewal action permitted by this clause will be mailed to the Policyholder at the last address shown in Delta Dental's records. If We fail to provide You with 45 days written notice, coverage shall remain in effect at the existing Premium until 45 days after notice is given or until the effective date of replacement coverage is obtained by the Enrollee.

If Delta Dental decides to discontinue offering this Policy, we will provide You with a minimum of 90 days advance notice before the date of nonrenewal of coverage.

Termination of Coverage

Policyholders have the right to terminate coverage under this Policy by notifying Us of intent to terminate this Policy. Termination of this Policy and coverage for You will be effective the day the Policyholder requests termination and We will refund the unearned portion of any premium paid before this Policy was terminated. Reasonable notice by You is defined as at least fourteen days before the requested effective date of termination.

A full refund of Premium will be issued when a written request for Policy cancellation is received. A Premium refund will be issued based upon the amount of Premium that has been paid in advance. Claims received prior to the effective date of cancellation will be processed in accordance with standard processing guidelines under this policy.

You may keep this Policy in force by timely payment of the Premiums. However, We 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 the You no longer meets eligibility requirements); however, if You move and no longer reside in the state of Florida, please contact our Customer Service Center at 888-282-8784;
- 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 Policyholder or Dependent Enrollee when applying for this coverage or filing a claim for Benefits if coverage is terminated, we will provide 45 days written notice prior to termination. If We fail to provide You with 45 days written notice, coverage shall remain in effect at the existing Premium until 45 days after notice is given or until the effective date of replacement coverage is obtained by the Enrollee. Claims received prior to the effective date of cancellation will be processed in accordance with standard processing guidelines under this policy; or

- We cease to renew all Policies issued on this form to residents of the state where You live. We will provide You with 90 days written advance notice prior to termination.

If coverage is terminated, we will send a written notice to the Policyholder providing reason(s) why coverage is terminated and the date that coverage will end. We will not pay for services received after Your coverage ends. However, if We accept Premium from You for coverage extending beyond the date of the event specified for termination listed above, we will continue to provide coverage through the date Premium is paid. Additionally, we will pay for the completion of Single Procedures started while You were eligible if they are completed within 31 days of the date coverage ended.

Reinstatement

If the renewal premium is not paid before the grace period ends, this Policy will lapse. Later acceptance of the premium by us, or by an agent authorized to accept payment without requiring an application for reinstatement, will reinstate this Policy 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. If we or our agent requires an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be reinstated as of the approval date. Lacking such approval, this Policy will be reinstated on the 45th day after the date of the conditional receipt unless we have previously written You of its disapproval.

The reinstated Policy will cover only loss that results from an injury sustained after the date of reinstatement or sickness that starts more than ten (10) days after such date. In all other respects, the rights of You and us will remain the same, subject to any provisions noted on or attached to the reinstated Policy. Any premiums we accept for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than sixty (60) days before the reinstatement date.

OVERVIEW OF DENTAL BENEFITS

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

Benefits, Limitations and Exclusions

We will pay for Benefits described in the Attachments that are a part of this Policy. This Policy covers several categories of dental services when a Provider furnishes them and when they are necessary and within the standards of generally accepted dental practice standards. Claims will be processed in accordance with our standard processing policies. The processing policies may be revised at the beginning of a Calendar Year to comply with annual CDT changes made by the American Dental Association and to reflect changes in generally accepted dental practice standards. We will provide at least 30 days advance notice of such changes to the Policyholder.

We will use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. If You receive dental services from a Provider outside the state of Florida, the Provider will be paid according to Our network payment provisions for said state and according to the terms of this Policy.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under this Policy. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, subject to certain limitations, and You are responsible for paying the balance. What You pay is called Your coinsurance ("Enrollee Coinsurance"). You may have to satisfy a Deductible before we will pay Benefits. You pay Your Coinsurance even after a Deductible has been met.

The amount of Your Coinsurance will depend on the type of service and the Provider furnishing the service (see section titled "*Selecting Your Provider*"). Providers are required to collect Your Coinsurance for covered services. If the Provider discounts, waives or rebates any portion of Your Coinsurance to You, we will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to Your advantage to select PPO Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for You. Please refer to the section titled "*Selecting Your Provider*" for more information.

Pre-Treatment Estimates

Pre-Treatment Estimate requests are not required; however, Your Provider may file a Claim Form before beginning treatment, showing the services to be provided to You. We will estimate the amount of Benefits payable under this Policy for the listed services. By asking Your Provider for a Pre-Treatment Estimate from us before You receives any prescribed treatment, You will have an estimate up front of what we will pay and the difference You will need to pay. The Benefits will be processed according to the terms of this Policy when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days unless other services are received after the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:

- the date this Policy terminates;

- the date Your coverage ends; or
- the date the Provider's agreement with Delta Dental ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if You are covered and meet all the requirements of the plan at the time the treatment You have planned is completed and may not take into account any Deductibles, so please remember to figure in Your Deductible if necessary.

SELECTING YOUR PROVIDER

Free Choice of Provider

You may see any Provider for Your covered treatment whether the Provider is a PPO Provider, Premier Provider or a Non-Delta Dental Provider. **This plan is a PPO plan and the greatest benefits – including out-of-pocket savings – occur when You choose a PPO Provider.** To take full advantage of Your Benefits, we highly recommend You verify a Provider's participation status within a Delta Dental network with Your dental office before each appointment. Review this section for an explanation of Our payment procedures to understand the method of payments applicable to Your Provider selection and how that may impact Your out-of-pocket costs.

Locating a PPO Provider

You may access information through our website at deltadentalins.com. You may also call our Customer Service Center and one of our representatives will assist You. We can provide You with information regarding a Provider's network participation, specialty and office location.

Choosing a PPO Provider

A PPO Provider potentially allows the greatest reduction in Your out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge that has been contractually agreed upon. Payment for covered services performed by a PPO Provider is based on the Maximum Contract Allowance.

Choosing a Premier Provider

A Premier Provider is a Delta Dental Provider; however, the Premier Provider has not agreed to the features of the PPO plan. The amount charged may be above that accepted by PPO Providers, and You will be responsible for balance billed amounts. Payment for covered services performed by a Premier Provider is based on the Maximum Contract Allowance, and You may be balance billed up to the Premier Provider's Contracted Fee.

Choosing a Non-Delta Dental Provider

If a Provider is a Non-Delta Dental Provider, the amount charged Your may be above that accepted by PPO Providers or Premier Providers, and You will be responsible for balance billed amounts. Payment for covered services performed by a Non-Delta Dental Provider is based on the Maximum Contract Allowance, and You may be balance billed up to the Provider's Submitted Fee.

Additional Obligations of PPO and Premier Providers

- The PPO Provider or Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Us after satisfaction of the Deductible and Your Coinsurance. You do not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.

- The PPO Provider or Premier Provider will complete the dental Claim Form and submit it to Us for reimbursement.
- The PPO Provider will accept PPO Provider's Contracted Fee as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and PPO Provider's Contracted Fees.

How to Submit a Claim

Claims for Benefits must be filed on a standard Claim Form that is available in most dental offices. PPO and Premier Providers will fill out and submit Your claims paperwork for You. Non-Delta Dental Providers may also provide this service upon Your request. If You receive services from a Non-Delta Dental Provider who does not provide this service, You can submit Your own claim directly to us. Please refer to the section titled "*Claim Form*" for more information.

Your dental office should be able to assist You in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Payment Guidelines

We do not pay PPO or Premier Providers any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If You or Your Provider files a claim for services more than 12 months after the date You received the services, payment may be denied. If the services were received from a Non-Delta Dental Provider, You are still responsible for the full cost. If the payment is denied because Your PPO or

Premier Provider failed to submit the claim on time, You may not be responsible for that payment. However, if You did not tell Your PPO or Premier Provider that You were covered under a Delta Dental Policy at the time You received the service, You may be responsible for the cost of that service.

If You have any questions about any dental charges, processing policies and/or how Your claim is paid, please contact us.

Provider Relationships

The Policyholder and Delta Dental agree to permit and encourage the professional relationship between Provider and Enrollee to be maintained without interference. Any PPO, Premier or Non-Delta Dental Provider, including any Provider or employee associated with or employed by them, who provides dental services to an Enrollee does so as an independent contractor and shall be solely responsible for dental advice and for performance of dental services, or lack thereof, to the Enrollee.

GRIEVANCES AND APPEALS

If You have questions about any services received, We recommend that You first discuss the matter with Your Provider. However, if You continue to have concerns, please call our Customer Service Center. You can also email questions by accessing the “Contact Us” section of our website at deltadentalins.com.

Grievances regarding eligibility, the denial of dental services or claims, the policies, procedures, operations of Delta Dental or the quality of dental services performed by the Provider may be directed in writing to us or by calling us toll-free at 888-282-8784.

When You write, please include the name of the Enrollee, the ID number and Your telephone number on all correspondence. You should also include a copy of the Claim Form, claim statement or other relevant information. Your claim statement will have an explanation of the claim review and any grievance process and time limits applicable to such process.

We will notify You and Your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason for the denial. You and Your Provider have at least 180 days after receiving a notice of denial to request a review in writing to Us giving reasons why You believe the denial was wrong. You may also ask Us to examine any additional information You include that may support Your grievance.

Send Your grievance to us at the address shown below:

Delta Dental Insurance Company
P.O. Box 1860
Alpharetta, GA 30023-1860

We will send You a written acknowledgment within five (5) days upon receipt of Your grievance. We will make a full and fair review within 30 days after we receive the grievance. We may ask for more documents if needed. We will send You a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Policy, we shall consult with a Dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

Appeals

If You believe You need further review of Your claim, You may contact Your state insurance regulatory agency.

PREMIUM PAYMENT RESPONSIBILITIES

Your Premium is determined by the plan design chosen at the time of enrollment and by the age of Enrollees. The Policyholder is responsible for making Premium payments when submitting their application for enrollment under this Policy. 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. We will provide at least 45 days advance written notice to You prior to any Premium change.

Changing Payment Options

Payment options may be changed at any time. The effective date of any change is the date of the next scheduled payment based on Your new billing period. You can change Your payment option by visiting our website at deltadentalins.com or by contacting our Customer Service Center toll-free at 888-282-8784.

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 shall continue in force. If we do not receive payment at the end of the grace period, we will send You written notice of coverage termination at least 10 days prior to termination. Your coverage will terminate effective the last day of the month for which we received payment. Claims received prior to the effective date of cancellation will be processed in accordance with standard processing guidelines under this policy.

GENERAL PROVISIONS

Entire Policy; Changes

This Policy, with the application and Attachments, constitutes the entire contract of insurance between the parties. The Policy will be accompanied by the Outline of Coverage. No change in this Policy will be valid unless 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 is found by a court or other authority to be illegal, void or not enforceable, then such Policy or amendment shall not be rendered invalid, but shall be construed and applied in accordance with such conditions and provisions as would have applied had such Policy or amendment been 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.

Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, information and records relating to the treatment provided to You as may be required to administer the claim. Examination may be required by a dental consultant retained by us, at our own expense in or near Your community or residence. We will in every case hold such information and records confidential.

Written Notice of Claim/Proof of Loss

We must be given written notice of claim or written proof of loss within 12 months after the date of service or loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give written proof in the time required provided that the proof is filed as soon as reasonably possible. A notice of claim submitted by You, on Your behalf, or on behalf of Your beneficiary to us or to our authorized agent, with information sufficient to identify You will be considered notice of claim.

All written claims or proofs of loss must be given to us within 12 months of the termination of this Policy.

Send Your Notice of Claim/Proof of Loss to us at the address shown below:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Claim Form

We will within 15 days after receiving a notice of a claim provide You or Your Provider with a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If we do not send You or Your Provider a Claim Form within 15 days after You or Your Provider gave us notice regarding a claim, the requirements for proof of loss outlined in the section "*Written Notice of Claim/Proof of Loss*" above will be deemed to have been complied with as long as You give us written proof that explains the type and the extent of the loss that You are making a claim for within the time established for filing proofs of loss. You may also download a Claim Form from our website at deltadentalins.com.

Time of Payment

Claims payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be processed no later than (paid or denied):

- within 45 days after receipt of due written proof of such loss. If additional information is requested to process the claim, we will notify You and Your Provider within 45 days of written proof of loss; or
- within 60 days after the requested information is received in the form required by the terms of this Policy for any disputed portion of the claim.

We will notify You and Your Provider of any additional information needed to process the claim within these time periods.
Claims not processed (paid or denied) within 120 days of receipt are subject to a charge of 10 percent interest per annum.

To Whom Benefits Are Paid

It is not required that the service be provided by a specific Provider. Payment for services provided by a PPO or Premier Provider will be made directly to the Provider. Any other payments provided by this Policy will be made to You unless You request in writing when filing a proof of claim that the payment be made directly to the Provider providing the services. All Benefits not paid to the Provider will be payable to You or to Your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to their parent, guardian or other person actually supporting them.

Change of Beneficiary

You may change the beneficiary at any time by giving Us written notice. The beneficiary's consent is not required for this or any other change in the Policy, unless the designation of the beneficiary is irrevocable.

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 fraudulent misstatements are made by You in the application for coverage that would materially affect the rates, we reserve the right to adjust future Premiums and claims to reflect Your actual circumstances or terminate Your Policy.

Legal Actions

No legal action may be brought to recover on this Policy within 60 days after proof of loss has been given in accordance with requirements of this Policy. No such action may 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

Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which the Enrollee resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Holding Company

Delta Dental is a member of the insurance holding company system of Delta Dental of California (the "Enterprise"). There are service agreements between and among the controlled member companies of the Enterprise. Delta Dental is a party to some of these service agreements. It is expected that the services, which include certain ministerial tasks, will continue to be performed by these controlled member companies, which operate under strict confidentiality and/or business associate agreements. All such service agreements have been approved by the respective regulatory agencies.

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 shall enter into a separate business associate agreement with Delta Dental providing that the TPA shall meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

Non-Discrimination

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

Delta Dental:

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

If You need these services, contact Delta Dental's Customer Service Center at 888-282-8784.

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

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
Telephone Number: 888-282-8784
Website Address: deltadentalins.com

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

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

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

Attachment A
Deductibles, Maximums and Policy Benefit Levels

Deductibles & Maximums	
Annual Deductible[1]	$50 per Enrollee each Calendar Year $150 per family each Calendar Year
Deductible waived for	Diagnostic and Preventive Services
Orthodontic Deductible	$50 per Enrollee each Calendar Year
Annual Maximum	$2,000 per Enrollee per Calendar Year
Orthodontic Maximum	$1,500 per Enrollee per lifetime

Policy Benefit Levels		
Dental Service Category	**Delta Dental PPO Providers**[2]	**Delta Dental Premier and Non-Delta Dental Providers**[2]
Diagnostic and Preventive Services	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Orthodontic Services	50%	50%
Waiting Periods	Basic Services are limited to Enrollees who have been covered under this Policy for 6 consecutive months. Major Services and Orthodontic Services are limited to Enrollees who have been covered under this Policy for 12 consecutive months.[3]	

[1] Annual Deductible applies to all service categories. Benefits will apply after the annual Deductible is satisfied.

[2] Delta Dental will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for covered services. Note: While Delta Dental will pay the same Policy Benefit Level for covered services performed by a PPO Provider, Premier Provider and a Non-Delta Dental Provider, the amount charged to Enrollees for covered services performed by a Premier Provider or Non-Delta Dental Provider may be above that accepted by PPO Providers, and Enrollees will be responsible for balance-billed amounts.

[3] Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from his or her own effective date of coverage. No exceptions or credits are given for prior coverage provided under any plan.

Attachment B
Services, Limitations and Exclusions

Description of Dental Services
We will pay or otherwise discharge the Policy Benefit Level shown in Attachment A for the following services:

- **Diagnostic and Preventive Services**

(1)	Diagnostic:	procedures to aid the Provider in determining required dental treatment.
(2)	Preventive:	cleaning, including scaling in presence of generalized moderate or severe gingival inflammation – full mouth (periodontal maintenance is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
(3)	Sealants:	topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

- **Basic Services**

(1)	Palliative:	emergency treatment to relieve pain.
(2)	Restorative:	amalgam and resin-based composite restorations (fillings) and refabricated crowns for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
(3)	Specialist Consultations:	opinion or advice requested by a general dentist.

- **Major Services**

(1)	Crowns and Inlays/Onlays:	treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.

(2)	Prosthodontics:	procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
(3)	Oral Surgery:	extractions and certain other surgical procedures (including pre-and post-operative care).
(4)	Endodontics:	treatment of diseases and injuries of the tooth pulp.
(5)	Periodontics:	treatment of gums and bones supporting teeth.
(6)	General Anesthesia or IV Sedation:	when administered by a Provider for covered oral surgery or selected endodontic and periodontal surgical procedures.
(7)	Denture Repairs:	repair to partial or complete dentures, including rebase procedures and relining.

- **Orthodontic Services**
  Procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function.

- ***Note on additional Benefits during pregnancy***
  When an Enrollee is pregnant, We will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Policy include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Limitations

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called “optional services”. optional services also include the use of specialized techniques instead of standard procedures.

Examples of optional services:

a) a composite restoration instead of an amalgam restoration on posterior teeth;
b) a crown where a filling would restore the tooth;
c) an inlay/onlay instead of an amalgam restoration;
d) porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown); or
e) an overdenture instead of denture.

If You receive optional services, an alternate Benefit will be allowed, which means We will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the optional service. You will be responsible for the difference between the higher cost of the optional service and the lower cost of the customary service or standard procedure.

(2) Exam and cleaning limitations:

a) We will pay for oral examinations (except after-hours exams and exams for observation) and cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (including periodontal maintenance or any combination thereof) no more than twice in a Calendar Year.
b) A full mouth debridement is allowed once in a lifetime, when You have no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three years, and counts toward the cleaning frequency in the year provided.
c) Note that periodontal maintenance, Procedures Codes that include periodontal maintenance and full mouth debridement are covered as a Basic Benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a diagnostic and preventive Benefit. See note on additional Benefits during pregnancy.

d) Caries risk assessments are allowed once in 12 months.
e) Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.

(3) Image limitations:
a) We will limit the total reimbursable amount to the Provider's Accepted Fee for a comprehensive intraoral series of radio graphic images when the fees for any combination of intraoral images in a single treatment series meet or exceed the Accepted Fee for a comprehensive intraoral series.
b) Benefits are limited to either one (1) comprehensive intraoral series or one (1) panoramic image once every 60 months.
c) If a panoramic image is taken in conjunction with a comprehensive intraoral series, We will limit reimbursement to the Provider's Accepted Fee for the comprehensive intraoral series, and the fee for the panoramic image will be the responsibility of the Enrollee.
d) Panoramic images are not considered part of a comprehensive intraoral series.
e) Bitewing images are limited to two (2) times per Calendar Year when provided to Enrollees under age 18 and one (1) time each Calendar Year for Enrollees age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
f) Bitewing images of any type are included in the fee of a comprehensive series when taken within 6 months of the comprehensive images.
g) Bitewing images are limited to two images for under age 10.
h) Image capture procedures are not separately billable services.

(4) Cone beam CT capture and interpretation are covered not more than once in any 12-month period. Interpretation of a diagnostic image only is covered for cone beam services. Cone beam interpretation is a covered Benefit when provided by a different Dentist/dental office than the Dentist/dental office who provided the cone bream capture only services.

(5) Topical application of fluoride solutions is limited to Enrollees to age 19 and no more than twice in a Calendar Year.

(6) Application of caries arresting medicament is limited to twice per tooth per Calendar Year.

(7) Space maintainer limitations:
   a) Except for distal shoe space maintainers, space maintainers are limited to the initial appliance and are a Benefit for an Enrollee to age 14.
   b) A distal shoe space maintainer - fixed – unilateral is limited to children 8 and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
   c) Recementation of space maintainer is limited to once per lifetime.
   d) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(8) Pulp vitality tests are allowed once per day when definitive treatment is not performed.

(9) Cephalometric images, oral/facial photographic images and diagnostic casts are covered once per lifetime in conjunction with orthodontic services only when orthodontic services are a covered benefit. If orthodontic services are covered, see Limitations as age limits may apply. However, 3D images are not a covered Benefit.

(10) Sealants are limited as follows:
   a) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without caries (decay) or restorations on the occlusal surface.
   b) repair or replacement of a sealant on any tooth within 24 months of its application is included in the fee for the original placement.

(11) Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a 12-month period and included if reported, with any other examination on the same date of service and Provider office.

(12) We will not cover replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.

(13) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

(14) The removal of an indirect restoration is a part of a subsequent restorative procedure.

(15) Prefabricated crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16. Replacement restorations within 24 months are included in the fee for the original restoration.

(16) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.

(17) Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(18) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.

(19) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(20) Pin retention is covered not more than once in any 24-month period.

(21) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required images or select Diagnostic procedures.

(22) Periodontal limitations:
   a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service.

b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same Dentist/dental office.
c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
d) Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
e) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
f) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
g) When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a basic benefit and are limited to once in a 24-month period.

(23) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

(24) When done in conjunction with the removal of an impacted tooth, complete bony, with unusual surgical complications, nerve dissection is part of that extraction procedure. Otherwise, nerve dissection is not a Benefit.

(25) Crowns and inlays/onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when We determine the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(26) Core buildup, including any pins, are covered not more than once in any 60 month period.

(27) Post and core services are covered not more than once in any 60 month year period.

(28) Crown repairs are covered not more than twice in any 60 month period. Crowns, inlays/onlays and fixed bridges include repairs for twenty four (24) months following installation.

(29) Denture repairs are covered not more than once in any six (6) month period except for fixed denture repairs which are covered not more than twice in any 60 month period.

(30) Prosthodontic appliances implants and/or implant supported prosthetics that were provided under Our Plan will be replaced only after 60 months have passed, except when We determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older.

(31) Implants and/or implant supported prosthetics are limited to Enrollees age 19 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under Our Plan will be made if We determine it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Our payment for implant removal is limited to one (1) for each implant in 60-months whether provided under Us or any other dental care plan.

(32) Repairs to implant/abutment supported prosthesis (crowns, bridges and dentures), are part of the prosthetic procedure, when done within 6 months of the initial prosthesis, by the same dentist/dental office.

(33) Replacement of an implant screw is part of the service to insert an implant or abutment supported prosthesis (crown, bridge or denture) when it is done within 6 months of the insertion of the prosthesis.

(34) Accessing and retorquing a loose implant screw is part of the service to replace an implant screw.

(35) Maintenance of an implant supported full arch fixed hybrid prosthesis is part of the denture service, when performed within 12 months of the insertion of the denture.

(36) The Socket Shield technique, partial extraction of the root of a tooth at the time of implant placement, is only a Benefit when done with simultaneous implant placement.

(37) 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.

(38) Recementation of crowns, inlays/onlays or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.

(39) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Delta Dental plan.

(40) We limit payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
   a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
   b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period.

c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
d) Recementation of fixed partial dentures is limited to once in a lifetime.

(41) Limitations on orthodontic services:
a) The maximum amount payable for each Enrollee is shown in Attachment A.
b) Benefits for orthodontic services will be provided in periodic payments based on Your continuing eligibility.
c) Benefits are not paid to repair or replace any orthodontic appliance received under this plan.
d) Benefits are not paid for orthodontic retreatment procedures.
e) Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered. All orthodontic services, including direct to consumer orthodontics, must be provided by a licensed Dentist authorized to deliver care in Your state. Claims for services that are not provided by a Dentist are not eligible for reimbursement.
f) The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.
g) Limited orthodontic treatment (any dentition) and comprehensive orthodontic treatment (any dentition) are part of comprehensive orthodontic treatment with orthognathic surgery.

(42) Frenulectomy and frenuloplasty are only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician or the frenum is contributing to the presence of a large diastema(s).

(43) Bleaching is limited to Enrollees age 16 or older. Internal bleaching is limited to once in a 60 month period. External bleaching is limited to once in a 24-month period.

(44) Limitations on occlusal guard services:
a) Occlusal guards are limited to one (1) in a 60-month period.
b) After six (6) months from initial placement, occlusal guard repair or relining will be limited to one (1) in a 24-month period.
c) After six (6) months from initial placement, occlusal guard adjustments will be limited to one (1) in a 12-month period.

(45) Fabrication of athletic mouthguards is limited to once every24 months for patients 18 and younger.

(46) The fee for synchronous/asynchronous Teledentistry services are considered inclusive in overall patient management and are not separately payable service.

Exclusions

We do not pay Benefits for:

(1) treatment of injuries or illness paid under workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(2) cosmetic surgery or procedures for purely cosmetic reasons, except for bleaching.

(3) administration of neuromodulators is not a Benefit of the plan.

(4) administration of dermal fillers is not a Benefit of the plan.

(5) maxillofacial prosthetics.

(6) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.

(7) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, and cleft lip (unless services for cleft palate and cleft lip are provided to a covered child under the age of 18), upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.

(8) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments and abfraction.

(9) any single procedure provided prior to the date You became eligible for services under this plan.

(10) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(11) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.

(12) extraoral grafts (grafting of tissues from extraoral sites of the Enrollee's own body to their oral tissues).

(13) laboratory processed crowns for Enrollees under age 12.

(14) fixed bridges and removable partials for Enrollees under age 16.

(15) interim implants, endodontic endosseous implant, and extraoral implants.

(16) indirectly fabricated resin-based inlays/onlays.

(17) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(18) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(19) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, image duplications, cancer screening, tobacco counseling or broken appointments.

(20) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(21) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(22) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.

(23) deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

(24) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(25) the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Policy or was covered under any dental care plan with Us. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(26) services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the orthodontic services section, if applicable.

(27) missed and/or cancelled appointments.

(28) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

(29) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

(30) dental case management motivational interviewing and patient education to improve oral health literacy.

(31) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

(32) extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.

(33) diabetes testing.

(34) corticotomy (specialized oral surgery procedure associated with orthodontics).

(35) antigen or antibody testing.

(36) counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

(37) services or supplies for sleep apnea.

(38) cone beam image capture only is not a covered Benefit.

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809
888-282-8784
deltadentalins.com

Delta Dental Individual & Family™

Delta Dental PPO™
Premium Plan for Families

Dental Coverage with Limited Benefits

Outline of Coverage
For Policy Number: IENT-P-CORE-FL-24

Read your Policy carefully. This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance Policy and only the Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is therefore important that you READ YOUR POLICY CAREFULLY. The Policy provides benefits for dental care only. It does not pay benefits for any other type of loss such as medical or hospital expenses.

If you are not satisfied with the Policy for any reason, you may return the Policy within 10 days after you receive it. Mail or deliver it to Delta Dental Insurance Company ("Delta Dental"). Any premium paid will be refunded. The Policy will then be void from its start.

Renewal and Premium Changes	
Renewability:	**Renewable Subject to Delta Dental Consent** Delta Dental will provide 45 days advance written notice of any change in Premium at renewal. The Policyholder may keep this Policy in force for 12 months 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 Policyholder or Dependent Enrollee when applying for this coverage or filing a claim for Benefits; ▪ the Policyholder failing to comply with material provisions of this Policy; ▪ the Policyholder moving out of the state in which this Policy was issued; or ▪ Delta Dental ceasing to renew all Policies issued on this form to residents of the state where you live. At least 45 days notice of any non-renewal action permitted by this clause will be mailed to the Policyholder at the last address shown in Delta Dental's records. If Delta Dental fails to provide you with 45 days written notice, coverage shall remain in effect at the existing Premium until 45 days after notice is given or until the effective date of replacement coverage is obtained by the Enrollee. If Delta Dental decides to discontinue offering this Policy, we will provide you with a minimum of 90 days advance notice before the date of nonrenewal of coverage.
Right to Change Premium:	Your Premium rate is guaranteed for each Policy Year based upon the new Enrollee rates in force at the time of your enrollment. Delta Dental will provide at least 45 days advance written notice prior to any Premium change.

Deductibles & Maximums	
Annual Deductible	$50 per Enrollee each Calendar Year $150 per family each Calendar Year
Orthodontic Deductible	$50 per Enrollee each Calendar Year
Annual Maximum	$1,500 per Enrollee per Calendar Year
Orthodontic Maximum	$1,500 per Enrollee per lifetime

Policy Benefit Levels		
Dental Service Category	**Delta Dental PPO Providers[1]**	**Delta Dental Premier and Non-Delta Dental Providers[1]**
Diagnostic and Preventive Services	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Orthodontic Services	50%	50%
Waiting Periods	Basic Services are limited to Enrollees who have been covered under this Policy for 6 consecutive months. Major Services and Orthodontic Services are limited to Enrollees who have been covered under this Policy for 12 consecutive months.[2]	

[1] Delta Dental will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for covered services. Note: While Delta Dental will pay the same Policy Benefit Level for covered services performed by a PPO Provider, Premier Provider and a Non-Delta Dental Provider, the amount charged to Enrollees for covered services performed by a Premier Provider or Non-Delta Dental Provider may be above that accepted by PPO Providers, and Enrollees will be responsible for balance-billed amounts.

[2] Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from his or her own effective date of coverage. No exceptions or credits are given for prior coverage provided under any plan.

Description of Dental Services

We will pay or otherwise discharge the Policy Benefit Level shown in Attachment A for the following services:

- **Diagnostic and Preventive Services**

(1)	Diagnostic:	procedures to aid the Provider in determining required dental treatment.
(2)	Preventive:	cleaning, including scaling in presence of generalized moderate or severe gingival inflammation – full mouth (periodontal maintenance is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
(3)	Sealants:	topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

- **Basic Services**

(1)	Palliative:	emergency treatment to relieve pain.
(2)	Restorative:	amalgam and resin-based composite restorations (fillings) and prefabricated crowns for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
(3)	Specialist Consultations:	opinion or advice requested by a general dentist.

- **Major Services**

(1)	Crowns and Inlays/Onlays:	treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
(2)	Prosthodontics:	procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.

(3)	Oral Surgery:	extractions and certain other surgical procedures (including pre-and post-operative care).
(4)	Endodontics:	treatment of diseases and injuries of the tooth pulp.
(5)	Periodontics:	treatment of gums and bones supporting teeth.
(6)	General Anesthesia or IV Sedation:	when administered by a Provider for covered oral surgery or selected endodontic and periodontal surgical procedures.
(7)	Denture Repairs:	repair to partial or complete dentures, including rebase procedures and relining.

- **Orthodontic Services**
  Procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function.

- ***Note on additional Benefits during pregnancy***
  When an Enrollee is pregnant, We will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Policy include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Limitations

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called “optional services”. Optional services also include the use of specialized techniques instead of standard procedures.

Examples of optional services:

a) a composite restoration instead of an amalgam restoration on posterior teeth;
b) a crown where a filling would restore the tooth;
c) an inlay/onlay instead of an amalgam restoration;
d) porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown); or
e) an overdenture instead of denture.

If an Enrollee receives optional services, an alternate Benefit will be allowed, which means We will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the optional service. You will be responsible for the difference between the higher cost of the optional service and the lower cost of the customary service or standard procedure.

(2) Exam and cleaning limitations:
   a) We will pay for oral examinations (except after-hours exams and exams for observation) and cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (including periodontal maintenance or any combination thereof) no more than twice in a Calendar Year**.**
   b) A full mouth debridement is allowed once in a lifetime, when the Enrollee has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three years, and counts toward the cleaning frequency in the year provided.
   c) Note that periodontal maintenance, Procedures Codes that include periodontal maintenance and full mouth debridement are covered as a Basic Benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a diagnostic and preventive Benefit. See note on additional Benefits during pregnancy.
   d) Caries risk assessments are allowed once in 12 months.
   e) Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.

(3) Image limitations:
   a) We will limit the total reimbursable amount to the Provider's Accepted Fee for a comprehensive intraoral series of radio graphic images when the fees for any combination of intraoral images in a single treatment series meet or exceed the Accepted Fee for a comprehensive intraoral series.
   b) Benefits are limited to either one (1) comprehensive intraoral series or one (1) panoramic image once every 60 months.
   c) If a panoramic image is taken in conjunction with a complete intraoral series, We will limit reimbursement to the Provider's Accepted Fee for the comprehensive intraoral series, and the fee for the panoramic image will be the responsibility of the Enrollee.
   d) Panoramic images are not considered part of a comprehensive intraoral series.

e) Bitewing images are limited to two (2) times per Calendar Year when provided to Enrollees under age 18 and one (1) time each Calendar Year for Enrollees age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
f) Bitewing images of any type are included in the fee of a comprehensive series when taken within 6 months of the comprehensive images.
g) Bitewing images are limited to two images for under age 10.
h) Image capture procedures are not separately billable services.

(4) Cone beam CT capture and interpretation are covered not more than once in any 12-month period. Interpretation of a diagnostic image only is covered for cone beam services. Cone beam interpretation is a covered Benefit when provided by a different Dentist/dental office than the Dentist/dental office who provided the cone bream capture only services.

(5) Topical application of fluoride solutions is limited to Enrollees to age 19 and no more than twice in a Calendar Year.

(6) Interim caries arresting medicament application is limited to twice per tooth per Calendar Year.

(7) Space maintainer limitations:
a) Except for distal shoe space maintainers, space maintainers are limited to the initial appliance and are a Benefit for an Enrollee to age 14.
b) A distal shoe space maintainer - fixed – unilateral is limited to children 8 and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
c) Recementation of space maintainer is limited to once per lifetime.
d) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(8) Pulp vitality tests are allowed once per day when definitive treatment is not performed.

(9) Cephalometric images, oral/facial photographic images and diagnostic casts are covered once per lifetime in conjunction with orthodontic services only when orthodontic services are a covered Benefit. If orthodontic services are covered, see Limitations as age limits may apply. However, 3D images are not a covered benefit.

(10) Sealants are limited as follows:
   a) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without caries (decay) or restorations on the occlusal surface.
   b) repair or replacement of a sealant on any tooth within 24 months of its application is included in the fee for the original placement.

(11) Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a 12-month period and included if reported, with any other examination on the same date of service and Provider office.

(12) We will not cover replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.

(13) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

(14) The removal of an indirect restoration is a part of a subsequent restorative procedure.

(15) Prefabricated crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16. Replacement restorations within 24 months are included in the fee for the original restoration.

(16) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.

(17) Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(18) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.

(19) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(20) Pin retention is covered not more than once in any 24 month period.

(21) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required images or select Diagnostic procedures.

(22) Periodontal limitations:
- a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service.
- b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same dentist/dental office.
- c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
- d) Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
- e) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
- f) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
- g) When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a basic benefit and are limited to once in a 24-month period.

(23) Oral surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

(24) When done in conjunction with the removal of an impacted tooth, complete bony, with unusual surgical complications, nerve dissection is part of that extraction procedure. Otherwise, nerve dissection is not a Benefit.

(25) Crowns and inlays/onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when We determine the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(26) Core buildup, including any pins, are covered not more than once in any 60 month period.

(27) Post and core services are covered not more than once in any 60 month year period.

(28) Crown repairs are covered not more than twice in any 60 month period. Crowns, inlays/onlays and fixed bridges include repairs for twenty four (24) months following installation.

(29) Denture repairs are covered not more than once in any six (6) month period except for fixed denture repairs which are covered not more than twice in any 60 month period.

(30) Prosthodontic appliances implants and/or implant supported prosthetics that were provided under Our program will be replaced only after 60 months have passed, except when We determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older.

(31) Implants and/or implant supported prosthetics are limited to Enrollees age 19 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under Our program will be made if We determine it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Our payment for implant removal is limited to one (1) for each implant in 60-months whether provided under Us or any other dental care plan.

(32) Repairs to implant/abutment supported prosthesis (crowns, bridges and dentures), are part of the prosthetic procedure, when done within 6 months of the initial prosthesis, by the same dentist/dental office.

(33) Replacement of an implant screw is part of the service to insert an implant or abutment supported prosthesis (crown, bridge or denture) when it is done within 6 months of the insertion of the prosthesis.

(34) Accessing and retorquing a loose implant screw is part of the service to replace an implant screw.

(35) Maintenance of an implant supported full arch fixed hybrid prosthesis is part of the denture service, when performed within 12 months of the insertion of the denture.

(36) The Socket Shield technique, partial extraction of the root of a tooth at the time of implant placement, is only a Benefit when done with simultaneous implant placement.

(37) 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.

(38) Recementation of crowns, inlays/onlays or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.

(39) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Delta Dental plan.

(40) We limit payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
   a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
   b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period.

c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
d) Recementation of fixed partial dentures is limited to once in a lifetime.

(41) Limitations on orthodontic services:
a) The maximum amount payable for each Enrollee is shown in Attachment A.
b) Benefits for orthodontic services will be provided in periodic payments based on Your continuing eligibility.
c) Benefits are not paid to repair or replace any orthodontic appliance received under this plan.
d) Benefits are not paid for orthodontic retreatment procedures.
e) Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered. All orthodontic services, including direct to consumer orthodontics, must be provided by a licensed Dentist authorized to deliver care in Your state. Claims for services that are not provided by a Dentist are not eligible for reimbursement.
f) The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.
g) Limited orthodontic treatment (any dentition) and comprehensive orthodontic treatment (any dentition) are part of comprehensive orthodontic treatment with orthognathic surgery.

(42) Frenulectomy and frenuloplasty are only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician or the frenum is contributing to the presence of a large diastema(s).

(43) Bleaching is limited to Enrollees age 16 or older. Internal bleaching is limited to once in a 60 month period. External bleaching is limited to once in a 24-month period.

(44) Limitations on occlusal guard services:
a) Occlusal guards are limited to one (1) in a 60-month period.
b) After six (6) months from initial placement, occlusal guard repair or relining will be limited to one (1) in a 24-month period.
c) After six (6) months from initial placement, occlusal guard adjustments will be limited to one (1) in a 12-month period.

(45) Fabrication of athletic mouthguards is limited to once every 24 months for patients 18 and younger.

(46) The fee for synchronous/asynchronous teledentistry services are considered inclusive in overall patient management and are not separately payable service.

Exclusions

We do not pay Benefits for:

(1) treatment of injuries or illness paid under workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(2) cosmetic surgery or procedures for purely cosmetic reasons, except for bleaching.

(3) administration of neuromodulators is not a Benefit of the plan.

(4) administration of dermal fillers is not a Benefit of the plan.

(5) maxillofacial prosthetics.

(6) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.

(7) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, and cleft lip (unless services for cleft palate and cleft lip are provided to a covered child under the age of 18), upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.

(8) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments and abfraction.

(9) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(10) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(11) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.

(12) extraoral grafts (grafting of tissues from extraoral sites of the Enrollee's own body to their oral tissues).

(13) laboratory processed crowns for Enrollees under age 12.

(14) fixed bridges and removable partials for Enrollees under age 16.

(15) interim implants, endodontic endosseous implant, and extraoral implants.

(16) indirectly fabricated resin-based inlays/onlays.

(17) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(18) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(19) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, image duplications, cancer screening, tobacco counseling or broken appointments.

(20) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(21) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(22) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.

(23) deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

(24) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(25) The initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Policy or was covered under any dental care plan with Us. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(26) services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the orthodontic services section, if applicable.

(27) missed and/or cancelled appointments.

(28) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

(29) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

(30) dental case management motivational interviewing and patient education to improve oral health literacy.

(31) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

(32) extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.

(33) diabetes testing.

(34) corticotomy (specialized oral surgery procedure associated with orthodontics).

(35) antigen or antibody testing.

(36) counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

(37) services or supplies for sleep apnea.

(38) cone beam image capture only is not a covered Benefit.

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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