DeltaCare® USA

Dental Health Care Program for Eligible Employees and Dependents

Certificate of Coverage

FLD08

Underwritten and Administered by:

Delta Dental Insurance Company
1130 Sanctuary Parkway,
Suite 600
Alpharetta, GA 30009
800-422-4234

Delta Dental provides Benefits as a Prepaid Limited Health Service Organization as described in Chapter 636 of the Florida Statutes

deltadentalins.com

Certificate of Coverage

Introduction

DeltaCare® USA Dental Health Care Plan

This Certificate of Coverage ("COC") provides information about Your DeltaCare USA Dental Health Care Plan ("Plan") provided by Delta Dental Insurance Company ("Company"), on behalf of itself, and its affiliated companies. To offer these Benefits, the Contractholder has entered into a Group Dental Service Contract with Us.

This document, including the Contract and any attachments, provides the terms and conditions of Your Plan's coverage. Read this document carefully for an explanation of Your coverage, including the *Definitions* section for any terms with special or technical meanings.

Terms such as "You," "Your" and "Yourself" means the individuals who are covered. "We," "Us" and "Our" refers to the Company or Our Third Party Administrator ("Administrator").

Identification Card (ID)
ID cards are not required to receive dental services. However, when You receive dental services, Your Enrollee identification ("ID") number should be provided to Your Dentist. An ID card [will be mailed to each new Enrollee and] may be obtained by visiting Our website at [deltadentalins.com].

Contract
The Benefit explanations contained in this COC and the attachments are subject to all provisions of the Contract. In the event there is a conflict between the COC and the Contract, the Contract prevails. This document is not a Summary Plan Description under the Employee Retirement Income Security Act ("ERISA").

Contact Us
For more information, visit Our website at deltadentalins.com or call Customer Service at 800-422-4234 or You may submit an inquiry to:

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

Notice
This COC is a summary of Your dental Plan. This information is not a guarantee of covered Benefits, services, or payments.

Please read the following information so that You will know how to obtain dental services.

You must obtain dental Benefits from Your Contract Dentist or be referred for Specialist Services.

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Definitions

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

Authorization: The process by which We determine if a procedure or treatment is a referable Benefit under Your Plan.

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

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

Contract Dentist: A Dentist who provides services in general dentistry and who has agreed to provide Benefits under this Plan. Contract Dentists may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services. Referrals for Specialist Services must be obtained from Your Contract Dentist.

Contract Orthodontist: A Dentist who specializes in orthodontics and who has agreed to provide Benefits under this Plan. Services obtained from a Contract Orthodontist must be referred by Your Contract Dentist.

Contract Specialist: A Dentist who provides Specialist Services and who has agreed to provide Benefits under this Plan. Services obtained from a Contract Specialist must be referred by Your Contract Dentist.

Contract Year: Period of twelve (12) months starting on the Contract's Effective Date and or the anniversary of the Effective Date and each subsequent 12 months period thereafter.

Contract Term: The period during which coverage is in effect whether on a Calendar or Contract Year.

Contractholder: The group that enters into or executes this Contract to obtain dental coverage.

Copayment: The amounts set forth in *Schedule A Description of Benefits and Copayments* that You are responsible to pay the treating Dentist. Copayments must be paid at the time treatment is received.

Dependents ("Dependent Enrollees"): The Primary Enrollees eligible Dependents and any Individuals eligible to enroll for Benefits because of their relationship with the Primary Enrollee. And includes:

- The Spouse
- dependent children from birth to age 26 regardless or marital status
- as otherwise required by state or federal law.

Children include natural children, stepchildren, foster children, grandchildren, adopted children, custodial children, children for which the Primary Enrollee has been appointed legal guardian and newborn children, including a newborn child of a covered dependent child and children of a partner as recognized by the Contractholder.

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

Effective Date: The date the Contract or coverage begins.

Emergency Services: Dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing You in serious jeopardy. Emergency dental care is limited to palliative treatment for the elimination of dental pain.

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

Grace Period: A period of no less than 30 days after the Premium payment is due, in which a payment may be made and during which coverage will continue in effect, subject to the Premium payment by the end of the Grace Period.

Open Enrollment Period: The period the Contractholder has established for You to make changes in coverage selections for the next Contract Term.

Optional Treatment: Any alternative procedure that satisfies the same dental need as a covered procedure and is chosen by You subject to the limitations and exclusions described in the Schedules attached to this COC.

Out-of-Network: Treatment by a Dentist who has not signed a contract with Us to provide Benefits under this Plan. Also referred to as Non-participating Dentist.

Plan: Dental Benefits selected by the Contractholder and provided under the Contract, COC and any attachments.

Premium: Payment made in consideration of dental coverage.

Schedules: Dental services and procedures and applicable limitations and exclusions included under Your Plan and described in:
- *Schedule A, Description of Benefits and Copayments,* and
- *Schedule B, Limitations and Exclusions of Benefits*

Special Enrollment Period: The period of time outside Your Open Enrollment Period during which individuals eligible as Primary Enrollees or Dependents who experience certain qualifying events may enroll in this Plan.

Specialist Services: Services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics or pediatric dentistry. Specialist Services must be referred by a Contract Dentist.

Spouse: An individual who is a partner of the Primary Enrollee as:
1) as defined and as may be required to be treated as a Spouse by the laws of the state where this Contract is issued and delivered;
2) as defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides; and
3) as may be recognized by the Contractholder.

Eligibility and Enrollment - When Coverage Begins

Eligibility Requirements

The Contractholder is responsible for establishing eligibility and reporting enrollment to Us. We process enrollment as reported. You are eligible to enroll if You meet the eligibility requirements defined by the Contractholder.

Eligibility is determined by the Contractholder. We do not make eligibility determinations. We will update Our files to record the eligibility information provided by the Contractholder or its designee.

Your Dependents are eligible to enroll on the same date that You enroll. Later-acquired dependents become eligible as soon as they acquire dependent status.

Eligibility may be delayed for young children, under the age of 4, until the beginning of any Contract Term immediately following the child's birthday. For coverage to begin on young children, the eligibility notice and additional Premium payment must be received by Us within 30 days of the beginning of the Contract Term immediately following the child's birthday.

Children/students must be dependent upon You for support and maintenance.

There is no coverage under this Plan for Dependents on active military duty.

Medicare eligibility will not affect Your eligibility or Your Dependent's eligibility, if applicable.

Overage Children

1) The child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that began prior to reaching the limiting age;
2) The child is chiefly dependent on the Primary Enrollee for support; and
3) Proof of disability is provided within 30 days of the limiting age. Proof of disability will not be required more than one (1) time per year following a two year period after the Dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Primary Enrollee for support because of a physically or mentally disabling injury, illness or condition that began before the Dependent reaches the limiting age.

Enrollment Requirements

If the Contractholder is responsible for Your Premium, coverage will begin on the Contract's Effective Date.

If You are responsible for Your Premium:

- All Dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period or Special Enrollment Period.
- If You elect Dependent coverage, You must enroll all of Your Dependent Enrollees for coverage.

An exception for enrolling Dependent Enrollees within 30 days after they become eligible applies for certain young children. The eligibility date for such children may be delayed as outlined in the *Eligibility Requirements* section.

You:

- Must pay Premiums in the manner elected by the Contractholder and approved by Us, and
- May not drop coverage and may only make coverage changes during an Open Enrollment Period or Special Enrollment Period as a result of a qualifying status change.

A Dependent may not be enrolled under more than one Primary Enrollee.

A child who is eligible as a Primary Enrollee and a Dependent can be insured under the Contract as a Primary Enrollee or as a Dependent Enrollee but not both at the same time.

Special Enrollment Periods - Enrollment Changes
After Your Effective Date, You may change Your enrollment during an Open Enrollment Period or during a Special Enrollment Period as a result of a qualifying status change. Qualifying status changes include, but are not limited to, the following events:

- Marital status (Examples include but are not limited to: marriage, divorce, legal separation, annulment or death);
- Number of dependents (a child's birth, adoption of a child, placement of child for adoption, child to receive benefits required by court order, addition of a grandchild, stepchild or foster child or death of a child);
- Dependent child ceases to satisfy eligibility requirements;
- Employment status (change in Your or Your Dependent's employment status;
- Residence (You move);
- Court order requiring dependent coverage;
- Loss of other group coverage;
- Any other changes specified by applicable law or regulation.

Premiums
You are required to contribute towards the cost of Your coverage and the cost of Your Dependent's coverage, if applicable.

How to use the DeltaCare USA Plan

Choice of Contract Dentist
We will provide Your Plan with Contract Dentists at convenient locations. Upon enrollment, You should select a Contract Dentist from the list of Dentists provided at deltadentalins.com. If the

Contract Dentist You selected becomes unavailable, We will request You make a selection to another Contract Dentist.

You may change Your Contract Dentist by contacting the Customer Service at 800-422-4234. Requests to change Your Contract Dentist must be made prior to the 21st of the month to become effective on the first day of the following month.

We will request You select another Contract Dentist provided Your Contract Dentist:

- Is no longer taking further enrollment;
- No longer participates in the Plan; or
- Requests, for good cause, that You or Your Dependents be re-assigned to another Contract Dentist.

Any dental treatment in progress must be completed before You change to another Contract Dentist. For example, dental treatment may include:

- Partial or full dentures for which final impressions have been taken.
- All work on any tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Coordination of Care and Referrals

Services for Benefits must be provided by the assigned Contract Dentist. Specialist Services, obtained from a Contract Orthodontist or Contract Specialist, must be referred by Your Contract Dentist.

We have no obligation or liability with respect to services provided by Out-of-Network Dentists, with the exception of Emergency Services or Specialist Services referred by a Contract Dentist and authorized by Us. All authorized Specialist Services claims will be paid less any applicable Copayments.

Contract Dentist Termination

If Your assigned Contract Dentist no longer participates in this Plan, the Contract Dentist will complete all treatment in progress as described above.

Upon termination of a Contract Dentist's agreement, We will be liable for the completion of dental treatment begun prior to the termination of the agreement. For example, the terminating Contract Dentist will complete:

- A partial or full denture for which final impressions have been taken; or
- All work on any tooth upon which work as started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

If, for any reason, the Contract Dentist is unable to complete treatment, We will make reasonable and appropriate provisions for the completion of such dental treatment by another Contract Dentist.

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

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

Should We fail to pay a Contract Dentist, You will not be liable to that Dentist for any sums owed by Us. If You have not received Authorization for treatment from an Out-of-Network Dentist, and We fail to pay that Out-of-Network Dentist, You may be liable to that Dentist for the cost of services. For further clarification, see *"Emergency Services"*.

Emergency Services
If you have a dental emergency, You should contact Your Contract Dentist whenever possible. Contract Dentists maintain a twenty-four (24) hour Emergency Services system seven (7) days a week. If You are unable to reach the Contract Dentist for Emergency Services, You should call the Contact Center at 800-422-4234 for assistance in obtaining urgent care.

You may seek treatment from a Dentist other than Your Contract Dentist with no referral during non-business hours, of if You require Emergency Services and are 35 miles or more from Your Contract Dentist. You are only responsible for the Copayment(s) for any treatment received relating to the emergency.

Benefits for Emergency Services not provided by a Contract Dentist are limited to a maximum of $100.00 per emergency, per Enrollee, less the applicable Copayment. If this maximum is exceeded, You are responsible for any charges for services by a Dentist other than Your Contract Dentist. You must return to Your Contract Dentist for any necessary follow-up care.

Specialist Services
Specialist Services for oral surgery, endodontics, orthodontics, periodontics or pediatric dentistry must be referred by Your Contract Dentist.

If You require Specialist Services and there is no Contract Orthodontist or Contract Specialist to provide these services with 35 miles of Your home, the Contract Dentist must receive Authorization from Us to refer You to an Out-of-Network orthodontist or Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network orthodontist or Out-of-Network specialist that are not authorized by Us are not covered.

Claims for Reimbursement

Claims for covered Emergency Services or Specialist Services should be submitted for payment within 90 days of receiving treatment. Claims must be received within one (1) year of treatment date. The address for claims submission is:

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

Coordination of Benefits

If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, Benefits will be coordinated. If this plan is the "primary" plan, We will not reduce Benefits. If this plan is the "secondary" plan, We may reduce Benefits so that the total Benefits Paid or provided by all plans do not exceed 100% of total allowable expense.

But if this plan is the "secondary" plan, We determine Benefits after those of the primary plan and will pay the lesser of the amount that We would pay in the absence of any other dental benefit coverage or Your total out-of-pocket cost under the primary plan for Benefits covered under Your Plan.

In Order to determine which Plan is primary, We will use the following rules.

- The plan covering You as a Primary Enrollee is primary over a plan covering You as a dependent.
- The plan covering You as an employee is primary over a plan covering You as a dependent; except that if You are also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    - Secondary to the plan covering You as a dependent; and
    * Primary to the plan covering You as other than a dependent (e.g. a retired employee), then the Benefits of the plan covering You as a dependent are determined before those of the plan covering You as other than a dependent.
- Except as stated in the immediate above paragraph, when this plan and another plan cover the same child as a dependent of different persons, referred to as parents:
    * The Benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
    * If both parents have the same birthday, the Benefits of the plan covering one parent longer are determined before those of the plan covering the other parent for a shorter period of time.
    * However, if the other plan has no birthday rule, but has a rule based on the gender of the parent, and as a result, the plans do not agree on the order of Benefits, the rule in the other plan determines the order of Benefits.
- In the case of a dependent child of legally separated or divorced parents, the plan covering the child as a dependent of the parent with legal custody or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the child as a dependent of the parent with out legal custody.
- If there is a court decree establishing financial responsibility for the child's health care expenses, the Benefits of a plan covering the child as a dependent of the parent with financial responsibility will be determined before the Benefits of any other policy covering the child as a dependent child.

- If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the child's health care expenses, the plans covering the child will follow the order of Benefit determination rules outlined above.
- The Benefits of a plan covering You as an employee who is neither laid-off nor retired are determined before those of a plan covering You as a laid-off or retired employee. The same hold true if You are a dependent of a Primary Enrollee as a retiree or an employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- If Your coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination.
    * First, the Benefits of a plan covering the Enrollee as an employee or Primary Enrollee (or the Primary Enrollee's dependent).
    * Second, the Benefits under the continuation coverage.
    * If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of Benefits, the rule is ignored.
- If none of the above rules determines the order of Benefits, the Benefits of the plan covering an employee longer are determined before those of the plan covering that insured person for the shorter term. When determination cannot be made in accordance with the rules above, the Benefits of a plan that is a medical plan covering dental as a Benefit will be primary to a standalone dental plan.

Enrollee Claims Appeal Procedure

We will provide notification when any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If You have any complaint regarding eligibility, the denial of dental services or claims, Our policies, procedures or operations, or the quality of dental services performed by a Contract Dentist, You may call Contact Center at 800-422-4234 or a written complaint may be submitted to:

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

Written complaints must include, at a minimum the following information:

1) Patient's name

2) Primary Enrollees name, address, telephone number and identification number
3) Contractholder's name
4) Treating Dentist's name and location.

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

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgement of receipt of the complaint. Certain requests may require that you be referred to a Dentist in your area for clinical evaluation of the dental services provided. We will make a determination, in writing, within 30 days of receipt of a complaint or shall provide a written explanation if additional time is required to report on the complaint. In no event will the decision on the request for review be sent more than 90 days after Delta Dental receives it.

We will make a determination, in writing, within 30 days of receipt of a complaint or will provide a written explanation if additional time is required to report on the complaint. A review of the decision will be undertaken if a written request for an appeal of the determination is made within 30 days of the date of the written determination. We will undertake a full and fair review upon request. We may require additional documents in making such a review. A written response will be provided to You within 30 days after receipt of Your appeal and supporting documentation or a written explanation if additional time is required to issue the results.

An Enrollee who is dissatisfied with the decision may appeal in writing to the State of Florida Office of Insurance Regulation.

The State of Florida Office of Insurance Regulation may be contacted at any time, concerning any complaint or request for assistance, by writing to 200 East Gaines St., Tallahassee, FL 32399, or by calling the Office s statewide toll-free consumer helpline: 1-877-693-5236.

If Your Plan is subject to the ERISA, You may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if You have questions about Your rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The US Department of Labor may be contacted at:

Quality Management Department
Employee Benefits Security Administration
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Renewal and Termination of Benefits
This Plan renews on the anniversary of the Contract unless We provide notice of a change in Premiums or Benefits and the Contractholder does not accept the change. Your Benefits will terminate:

- As of the date that this Plan is terminated,
- You cease to be eligible under the terms of this Plan, or
- Your enrollment is canceled under the terms of this Plan.

We are not obligated to continue to provide Benefits to You or Your Dependents except for completion of dental treatment started when this Plan was in effect.

Cancellation of Enrollment
Subject to the *Enrollee Complaint Procedure*, the *Optional Continuation of Coverage* provision or the *Extension of Benefits or Conversion Privilege* below, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) Upon loss of eligibility as described in this COC.

- Upon 15 days written notice if
  b) The Premiums are not paid by, or on behalf of You, on the date due. However, You may continue to receive Benefits during the Grace Period and may be reinstated during the term of the Contract upon payment of any unpaid Premium; or
  c) if the Contract is terminated or not renewed.

2) Upon 45 days written notice if:
   a) the Enrollee's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that the Enrollee's continuing participation seriously impairs the organization's ability to provide services to other Enrollees;
   b) the Enrollee commits fraud or misrepresentation in applying for or presenting any claim for Benefits under this Contract;
   c) the Enrollee misuses the documents provided as evidence of Benefits available under the Contract; or
   d) the Enrollee furnishes incorrect or incomplete information to Delta Dental in order to fraudulently obtain services.

Prior to cancellation, Delta Dental will make every effort to resolve problems through the grievance procedures and will determine that the Enrollee's behavior is not due to the use of the services or mental illness.

The Contractholder will provide You with 15 days advance notice prior to cancellation or discontinuance of the Plan.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Extension of Benefits

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

1) The Dentist recommends the services to the patient in writing, and the services began, while coverage was in effect.
2) The services are not for routine examinations, prophylaxis, x-rays, sealants, or orthodontic services.
3) The services are provided within 90 days after the patient's coverage ended, and the coverage did not end because the patient (or, in the case of a dependent child, the child's parent) voluntarily terminated coverage.

The extension of Benefits ends at the earlier of:

1) the end of the 90-day period in 3) above; or

2) the day the patient becomes covered under another contract which does not exclude benefits for the procedure because of an elimination period or limitations.

All limitations and exclusions in the Contract will continue to apply during the extension.

Conversion Privilege

A person who has been continuously covered under the Contract for at least three months, and who loses that coverage, may convert to individual coverage within 31 days after losing the coverage without providing evidence of insurability. The person must pay premium at individual rates.

However, a person may not convert to individual coverage if the lost coverage is replaced by similar coverage within 31 days, or if the person lost coverage because he or she:

1) did not pay any required premium or contribution;
2) committed fraud or material misrepresentation in applying for coverage;
3) willfully and knowingly misused the Contract identification or member certificate;
4) willfully and knowingly gave incorrect or incomplete information to fraudulently obtain coverage;
5) left the geographic service area and does not intend to live there in the future; or
6) acted in a way that was so disruptive, unruly, abusive, or uncooperative that continuing the coverage would prevent Delta Dental from providing proper services to that person or to any other patients. However, before Delta Dental cancels an Enrollee's coverage it will try to resolve the problem through the grievance procedure and will make sure that the person's behavior is not caused by the services provided or mental illness.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

General Provisions

Compliance with Administrative Simplification, Security and Privacy Regulations

The parties will comply in all respects with applicable federal, state and local laws and regulations relating to administrative simplification, security and privacy of individually identifiable information including executing any agreements as required by

the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The parties agree that this Contract will incorporate terms as necessary and as applicable to execute the required agreements (i.e. business associate agreement) to comply with federal regulations issued under the HIPAA and HITECH Act or to comply with any other enacted administrative simplifications, security or privacy laws or regulations.

Conformity With Prevailing Laws
All legal questions about the Contract will be governed by the state where the Contract was entered into and is to be performed. We are subject to the requirements of Chapter 636 of the Florida Statutes. Any part of the Contract which conflicts with state or federal law is hereby amended to conform to the minimum requirements of such laws.

Entire Contract; Changes
This Contract, including the COC, Schedules and any Attachments, is the entire agreement between the parties. No agent has authority to change or waive any of its provisions. Changes are not valid unless approved by one of Our executive officers.

Incontestability
After this Contract has been in force for 3 years from the Effective Date, no statement made by the Contractholder will be used to void this Contract. No statement by an employee or You with respect to Your insurability will be used to reduce or deny a claim or contest the validity of insurance for You after that person's coverage has been in effect 3 years or more during the Your lifetime.

No claims for loss incurred or disability commencing after 3 years from the date of issue of the Contract will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed prior to the Effective Date of this Contract.

Legal Actions
No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor will an action be brought at all unless brought within 5 years from expiration of the time within which proof of loss is required by the Contract.

Misstatements on Application; Effect
In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage, all statements made by You will be deemed representations and not warranties. No such statement will be used in defense to a claim, unless it is contained in a written application.

Processing Policies
The Schedules explain the services covered under the Plan. Contract Dentists, Contract Orthodontists and Contract Specialists use professional judgment to determine appropriate services for You. Benefits performed by Contract Dentists, Contract Orthodontists and Contract Specialists are provided subject to any Copayments. You may contact Our Customer Service at 800-422-4234 for information regarding the dental care guidelines for DeltaCare USA.

Severability
If any part of the Contract, this COC, Attachments or an amendment to any of these documents is found by a court or other authority to be illegal, void or not enforceable, all other portions of these documents will remain in full force and effect.

Strike, Lay-off and Leave of Absence
You will not be covered for any dental services received while on strike, lay-off or leave of absence, other than as required under the Family & Medical Leave Act of 1993 (FMLA) or other applicable state or federal law*.

*Your coverage is not affected if You take a leave of absence under the FMLA or other applicable state or federal law. If You are currently paying any part of the Premium, You may choose to continue coverage. If You do not continue coverage during the leave, coverage may be resumed upon their return to active work as if no interruption occurred.

Important: FMLA does not apply to all organization, only those that meet certain guidelines. Refer to Your Human Resources unit for complete information.

Continuation of Coverage under USERRA

- As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if You are covered on the date Your USERRA leave of absence begins, You may continue dental coverage for Yourself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of:

- Twenty-four (24) months, beginning on the date the leave of absence begins, or;
- The date You fail to return to work within the time required by USERRA.

Continuation of Coverage under COBRA

The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides a way for You to continue to continue coverage for a period of time when employer coverage is lost. COBRA does not apply to all companies, only those that meet certain size guidelines. See Your Human Resources Department or website for complete information. We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

Non-Discrimination

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

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)
- 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 Care at 800-471-9925.

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 Services representative, or by mail.

DeltaCare USA
18000 Studebaker Road, Suite 530
Cerritos, CA 90703
Telephone Number: 866-530-9675
Website Address: deltadentalins.com

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

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

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

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **You should discuss all treatment options with Your Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2023 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	YOU PAY
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - comprehensive series of radiographic images - *limited to 1 series every 24 months*	No Cost

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0330	Panoramic radiographic image	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost

D0708	Intraoral - bitewing radiographic image - image capture only	No Cost
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Application of caries arresting medicament - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$40.00
D1526	Space maintainer - removable - bilateral, maxillary	$40.00
D1527	Space maintainer - removable - bilateral, mandibular	$40.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00

D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00
D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.
- Base or noble metal is the Benefit. If an inlay, onlay or indirectly fabricated post and core is made of high noble metal, an additional fee up to $100.00 per tooth will be charged for the upgrade. If covered, an additional laboratory charge also applies to a titanium crown.
- Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge of $150.00.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior	$15.00
D2392	Resin-based composite - two surfaces, posterior	$20.00
D2393	Resin-based composite - three surfaces, posterior	$25.00
D2394	Resin-based composite - four or more surfaces, posterior	$35.00
D2510	Inlay - metallic - one surface	$130.00
D2520	Inlay - metallic - two surfaces	$140.00
D2530	Inlay - metallic - three or more surfaces	$150.00

D2542	Onlay - metallic - two surfaces	$146.00
D2543	Onlay - metallic - three surfaces	$156.00
D2544	Onlay - metallic - four or more surfaces	$162.00
D2610	Inlay - porcelain/ceramic - one surface	$215.00
D2620	Inlay - porcelain/ceramic - two surfaces	$235.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$250.00
D2642	Onlay - porcelain/ceramic - two surfaces	$250.00
D2643	Onlay - porcelain/ceramic - three surfaces	$270.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$295.00
D2650	Inlay - resin-based composite - one surface	$100.00
D2651	Inlay - resin-based composite - two surfaces	$140.00
D2652	Inlay - resin-based composite - three or more surfaces	$170.00
D2662	Onlay - resin-based composite - two surfaces	$180.00
D2663	Onlay - resin-based composite - three surfaces	$195.00
D2664	Onlay - resin-based composite - four or more surfaces	$225.00
D2710	Crown - resin-based composite (indirect)	$110.00
D2712	Crown - 3/4 resin-based composite (indirect)	$110.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$195.00
D2740	Crown - porcelain/ceramic	$195.00
D2750	Crown - porcelain fused to high noble metal	$295.00
D2751	Crown - porcelain fused to predominantly base metal	$195.00
D2752	Crown - porcelain fused to noble metal	$195.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$295.00
D2780	Crown - 3/4 cast high noble metal	$295.00
D2781	Crown - 3/4 cast predominantly base metal	$195.00
D2782	Crown - 3/4 cast noble metal	$195.00
D2790	Crown - full cast high noble metal	$295.00
D2791	Crown - full cast predominantly base metal	$195.00
D2792	Crown - full cast noble metal	$195.00
D2794	Crown - titanium and titanium alloys	$295.00

D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	No Cost
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$35.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$35.00
D2930	Prefabricated stainless steel crown - primary tooth	$35.00
D2931	Prefabricated stainless steel crown - permanent tooth	$35.00
D2932	Prefabricated resin crown - *anterior primary tooth* .	$45.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$35.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition .	No Cost
D2949	Restorative foundation for an indirect restoration ..	$15.00
D2950	Core buildup, including any pins when required	$15.00
D2951	Pin retention - per tooth, in addition to restoration .	$15.00
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$15.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$15.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$15.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$15.00
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework.	$39.00
D2980	Crown repair necessitated by restorative material failure	$15.00
D2981	Inlay repair necessitated by restorative material failure	$15.00
D2982	Onlay repair necessitated by restorative material failure	$15.00

D2983	Veneer repair necessitated by restorative material failure	$15.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$5.00
D3221	Pulpal debridement, primary and permanent teeth	$5.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$5.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$5.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$5.00
D3310	Endodontic therapy, anterior tooth (excluding final restoration) - permanent teeth only	$75.00
D3320	Endodontic therapy, premolar tooth (excluding final restoration) - permanent teeth only	$120.00
D3330	Endodontic therapy, molar tooth (excluding final restoration) - permanent teeth only	$180.00
D3346	Retreatment of previous root canal therapy - anterior - permanent teeth only	$95.00
D3347	Retreatment of previous root canal therapy - premolar - permanent teeth only	$140.00
D3348	Retreatment of previous root canal therapy - molar - permanent teeth only	$200.00
D3410	Apicoectomy - anterior - permanent teeth only	$85.00
D3421	Apicoectomy - premolar (first root) - permanent teeth only	$85.00
D3425	Apicoectomy - molar (first root) - permanent teeth only	$85.00
D3426	Apicoectomy (each additional root) - permanent teeth only	$50.00
D3430	Retrograde filling - per root - permanent teeth only	$50.00
D3450	Root amputation - per root - permanent teeth only	$60.00
D3471	Surgical repair of root resorption - anterior	$85.00

D3472	Surgical repair of root resorption - premolar	$85.00
D3473	Surgical repair of root resorption - molar	$85.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$85.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$85.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$85.00
D3911	Intraorifice barrier	No Cost

D4000-D4999 V. PERIODONTICS

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$125.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$25.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$25.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$250.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$250.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$45.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$45.00

D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$45.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$36.00
D4921	Gingival irrigation with a medicinal agent - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

- Base or noble metal is the Benefit. If a fixed partial denture (bridge) is made of high noble metal, an additional fee up to $100.00 per tooth will be charged for the upgrade

D5110	Complete denture - maxillary	$225.00
D5120	Complete denture - mandibular	$225.00
D5130	Immediate denture - maxillary	$300.00
D5140	Immediate denture - mandibular	$300.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$275.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$275.00

D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$275.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$275.00
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery	$325.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$325.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$245.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$245.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$24.00
D5512	Repair broken complete denture base, maxillary	$24.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$10.00
D5611	Repair resin partial denture base, mandibular	$24.00
D5612	Repair resin partial denture base, maxillary	$24.00
D5621	Repair cast partial framework, mandibular	$24.00
D5622	Repair cast partial framework, maxillary	$24.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$24.00
D5640	Replace broken teeth - per tooth	$10.00
D5650	Add tooth to existing partial denture	$10.00
D5660	Add clasp to existing partial denture - per tooth	$10.00

D5710	Rebase complete maxillary denture - limited to 1 per denture during any 12 consecutive months	$50.00
D5711	Rebase complete mandibular denture - limited to 1 per denture during any 12 consecutive months	$50.00
D5720	Rebase maxillary partial denture - limited to 1 per denture during any 12 consecutive months	$50.00
D5721	Rebase mandibular partial denture - limited to 1 per denture during any 12 consecutive months	$50.00
D5725	Rebase hybrid prosthesis - limited to 1 per denture during any 12 consecutive months	$50.00
D5730	Reline complete maxillary denture (chairside) - limited to 1 per denture during any 12 consecutive months	$30.00
D5731	Reline complete mandibular denture (chairside) - limited to 1 per denture during any 12 consecutive months	$30.00
D5740	Reline maxillary partial denture (chairside) - limited to 1 per denture during any 12 consecutive months	$30.00
D5741	Reline mandibular partial denture (chairside) - limited to 1 per denture during any 12 consecutive months	$30.00
D5750	Reline complete maxillary denture (laboratory) - limited to 1 per denture during any 12 consecutive months	$50.00
D5751	Reline complete mandibular denture (laboratory) - limited to 1 per denture during any 12 consecutive months	$50.00
D5760	Reline maxillary partial denture (laboratory) - limited to 1 per denture during any 12 consecutive months	$50.00
D5761	Reline mandibular partial denture (laboratory) - limited to 1 per denture during any 12 consecutive months	$50.00
D5765	Soft liner for complete or partial removable denture - indirect - limited to 1 per denture during any 12 consecutive months	$50.00
D5820	Interim partial denture (including retentive/ clasping materials, rests, and teeth), maxillary - *limited to 1 in any 12 consecutive months*	No Cost
D5821	Interim partial denture (including retentive/ clasping materials, rests, and teeth), mandibular - *limited to 1 in any 12 consecutive months*	No Cost

D5850 Tissue conditioning, maxillary - limited to 1 per denture during any 12 consecutive months $10.00

D5851 Tissue conditioning, mandibular - limited to 1 per denture during any 12 consecutive months $10.00

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES

- The following are limited to no more than two (2) each per calendar year: Implants, Implant supported prosthetics and Implant abutments.

- Replacement is subject to a limitation requiring the existing implants and implant-supported prosthesis to be 5+ years old.

D6010 Surgical placement of implant body: endosteal implant $1,005.00

D6011 Surgical access to an implant body (second stage implant surgery) $145.00

D6012 Surgical placement of interim implant body for transitional prosthesis: endosteal implant $390.00

D6013 Surgical placement of mini implant $1,005.00

D6040 Surgical placement: eposteal implant $940.00

D6050 Surgical placement: transosteal implant $920.00

D6055 Connecting bar - implant supported or abutment supported $345.00

D6056 Prefabricated abutment - includes modification and placement $330.00

D6057 Custom fabricated abutment - includes placement $425.00

D6058 Abutment supported porcelain/ceramic crown $740.00

D6059 Abutment supported porcelain fused to metal crown (high noble metal) $750.00

D6060 Abutment supported porcelain fused to metal crown (predominantly base metal) $610.00

D6061 Abutment supported porcelain fused to metal crown (noble metal) $710.00

D6062 Abutment supported cast metal crown (high noble metal) $720.00

D6063 Abutment supported cast metal crown (predominantly base metal) $545.00

D6064 Abutment supported cast metal crown (noble metal) $690.00

D6065 Implant supported porcelain/ceramic crown $780.00

D6066	Implant supported crown - porcelain fused to high noble alloys	$750.00
D6067	Implant supported crown - high noble alloys	$730.00
D6068	Abutment supported retainer for porcelain/ceramic FPD	$725.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$750.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$485.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$660.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$750.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$415.00
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$425.00
D6075	Implant supported retainer for ceramic FPD	$780.00
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$750.00
D6077	Implant supported retainer for metal FPD - high noble alloys	$750.00
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$65.00
D6081	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	$65.00
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$610.00
D6083	Implant supported crown - porcelain fused to noble alloys	$710.00
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$655.00
D6086	Implant supported crown - predominantly base alloys	$545.00
D6087	Implant supported crown - noble alloys	$690.00
D6088	Implant supported crown - titanium and titanium alloys	$655.00
D6090	Repair implant supported prosthesis, by report	$130.00

D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$60.00
D6092	Re-cement or re-bond implant/abutment supported crown	$72.00
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$95.00
D6094	Abutment supported crown - titanium and titanium alloys	$655.00
D6095	Repair implant abutment, by report	$130.00
D6096	Remove broken implant retaining screw	$50.00
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$655.00
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$485.00
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$660.00
D6100	Surgical removal of implant body	$245.00
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	$125.00
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	$240.00
D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure.	$290.00
D6104	Bone graft at time of implant placement	$290.00
D6105	Removal of implant body not requiring bone removal or flap elevation	$6.00
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$925.00
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$925.00
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$1,015.00
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$1,015.00
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$925.00

D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$925.00
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	$1,015.00
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$1,015.00
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$415.00
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$415.00
D6122	Implant supported retainer for metal FPD - noble alloys	$425.00
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$620.00
D6190	Radiographic/surgical implant index, by report	$165.00
D6194	Abutment supported retainer crown, FPD - titanium and titanium alloys	$620.00
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$750.00
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	No Cost
D6198	Remove interim implant component	No Cost

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

- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.
- Base or noble metal is the Benefit. If an inlay, onlay or indirectly fabricated post and core is made of high noble metal, an additional fee up to $100.00 per tooth will be charged for the upgrade. If covered, an additional laboratory charge also applies to a titanium pontic or crown.
- Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge of $150.00.

D6210	Pontic - cast high noble metal	$295.00
D6211	Pontic - cast predominantly base metal	$195.00
D6212	Pontic - cast noble metal	$195.00
D6240	Pontic - porcelain fused to high noble metal	$295.00

D6241	Pontic - porcelain fused to predominantly base metal	$195.00
D6242	Pontic - porcelain fused to noble metal	$195.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$195.00
D6245	Pontic - porcelain/ceramic	$295.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$195.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$295.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$305.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$140.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$150.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$140.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$150.00
D6606	Retainer inlay - cast noble metal, two surfaces	$140.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$150.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$295.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$305.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$156.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$156.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$156.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$156.00
D6614	Retainer onlay - cast noble metal, two surfaces	$156.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$156.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00

D6722	Retainer crown - resin with noble metal	$195.00
D6740	Retainer crown - porcelain/ceramic	$295.00
D6750	Retainer crown - porcelain fused to high noble metal	$295.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$195.00
D6752	Retainer crown - porcelain fused to noble metal	$195.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$295.00
D6780	Retainer crown - 3/4 cast high noble metal	$295.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$195.00
D6782	Retainer crown - 3/4 cast noble metal	$195.00
D6784	Retainer crown - titanium and titanium alloys	$295.00
D6790	Retainer crown - full cast high noble metal	$295.00
D6791	Retainer crown - full cast predominantly base metal	$195.00
D6792	Retainer crown - full cast noble metal	$195.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$20.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - primary tooth	$6.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$6.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$15.00
D7220	Removal of impacted tooth - soft tissue	$40.00
D7230	Removal of impacted tooth - partially bony	$60.00
D7240	Removal of impacted tooth - completely bony	$80.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$80.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost

D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	$80.00
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$20.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$40.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$40.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	$60.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	$60.00
D7471	Removal of lateral exostosis (maxilla or mandible) .	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost

D8000-D8999 XI. ORTHODONTICS

- The listed comprehensive Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 (Start-up fee). Beyond 24 months of active treatment, an additional monthly fee of $75.00 applies.

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

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

Pre and post orthodontic records include:

	The benefit for pre-treatment records and diagnostic services includes:	No Cost
D0210	Intraoral - comprehensive series of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image	
D0350	2D oral/facial photographic image obtained intraorally or extra-orally	
D0470	Diagnostic casts	

D0801 3D dental surface scan - direct

D0802 3D dental surface scan - indirect

D0803 3D facial surface scan - direct

D0804 3D facial surface scan - indirect

D8070 Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* $1,800.00

D8080 Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* $1,800.00

D8090 Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children* $2,000.00

D8660 Pre-orthodontic treatment examination to monitor growth and development ..... No Cost

D8670 Periodic orthodontic treatment visit - *included in comprehensive case fee* ..... No Cost

D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)) - *includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee of $75.00 applies* ..... No Cost

D8681 Removable orthodontic retainer adjustment ..... No Cost

D8999 Unspecified orthodontic procedure, by report - *includes the START-UP FEE, which includes initial examination, diagnosis, consultation and initial banding* $350.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110 Palliative treatment of dental pain - per visit $10.00

D9211 Regional block anesthesia ..... No Cost

D9212 Trigeminal division block anesthesia ..... No Cost

D9215 Local anesthesia in conjunction with operative or surgical procedures ..... No Cost

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia ..... No Cost

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician $20.00

D9311 Consultation with a medical health care professional ..... No Cost

D9430 Office visit for observation (during regularly scheduled hours) - no other services performed $5.00

D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	$0.00
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9986	Missed appointment	$10.00
D9987	Canceled appointment	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

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

Accident Injury Benefit

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

We will pay up to 100% of the Contract Dentist's submitted fees, for expenses You incur for an accident injury, less any applicable Copayment(s), up to a maximum of $1,600.00 in any 12 month period.

Accident injury Benefits include the following procedure in addition to those listed in this document.

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

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

MAXIMUM BENEFIT

Accident injury benefits will be provided for You up to a maximum of $1,600.00 in any 12 month period.

Temporomandibular Joint (TMJ) Dysfunctions

TMJ dysfunctions are defined as disorders which have one or more of the following characteristics: Pain in the musculature associated with the TMJ, internal derangements of the TMJ, arthritic problems with the TMJ, or an abnormal range of motion or limitation of motion of the TMJ.

Benefits are listed dental procedures that are:

1. reasonable and appropriate for the treatment of a disorder of the TMJ, under all the factual circumstances of the case; and
2. effective for the control or elimination of one or more of the following, caused by a disorder of the TMJ: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and
3. recognized as effective, according to the professional standards of good dental practice; and
4. not experimental or primarily for cosmetic purposes.

We will pay 100 percent of the Dentist's submitted fees or of the fees actually charged for covered TMJ procedures, as noted herein, up to a lifetime Benefit maximum of $400.00, per Enrollee, less any applicable Copayment(s) for covered procedures. TMJ benefits are intended only for the treatment of the temporomandibular (jaw) joint and are limited to the procedures noted below when provided by a licensed Dentist as necessary according to the standards of generally accepted dental practice and only when provided for the treatment of the TMJ:

D7880 Occlusal orthotic device
D7899 Temporary repositioning appliance
D9310 Consultation
D9944, D9945, D9946 Occlusal guards
D9951 Occlusal adjustment - limited
D9952 Occlusal adjustment - complete

TMJ Benefits are subject to *Schedule B* and any definitions and/or other terms of the Contract not in conflict with the express terms of this Plan.

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

SCHEDULE B

Limitations of Benefits

1. Full mouth x-rays are limited to one set every 24 consecutive months and include any combination of periapicals, bitewings and/or panoramic film.
2. Bitewing x-rays are limited to not more than one series of four films in any six month period.
3. Diagnostic casts are limited to aid in diagnosis by the Contract Dentist for covered Benefits.
4. If a biopsy is preauthorized by Us to an oral surgeon, then examination of the resulting biopsy specimen is covered under codes D0472, D0473 or D0474 and available at no additional cost.
5. Prophylaxis or periodontal maintenance is limited to one procedure each six month period.
6. Benefits for sealants include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars through age nine and second molars through age 15. Benefits for sealants do not include the repair or replacement of a sealant on any tooth within three years of its application.
7. A filling is a benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
8. A crown is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five year limitation.
9. A covered metallic inlay, onlay, crown or fixed partial denture (bridge) using base or noble metal is available for listed Copayment(s). If You elect to have high noble metal used instead, the maximum additional cost of this material upgrade is $100.00 per tooth or pontic. For an indirectly fabricated post and core, the Benefit is for base or noble metal. If You elect to have a high noble metal indirectly fabricated post and core instead, the maximum additional cost of this material upgrade is $100.00 per tooth.

10. For molars, a covered inlay, onlay, crown, or unit of a fixed partial denture (bridge) is metallic without porcelain or other tooth-colored material. If You elect to have porcelain, porcelain-fused-to-metal, resin or resin-with-metal used instead, the maximum additional cost for this tooth-colored material upgrade is $150.00 per molar.
11. If a porcelain margin is also chosen by You for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is $75.00.
12. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:
    a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**
    b. One of the following:
        - The existing non-functional restoration/bridge/denture was placed five or more years prior to its replacement, **or**
        - If an existing partial denture is less than five years old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.
13. A direct or indirect pulp cap is a Benefit only on a vital permanent tooth with an open apex or a vital primary tooth.
14. With the exception of pulp caps and pulpotomies, endodontic procedures (e.g. root canal therapy, apicoectomy, retrofill, etc.) are only a benefit on a permanent tooth.
15. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.
16. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
17. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.
18. Coverage for the placement of a fixed partial denture (bridge) or removable partial denture:
    a. Fixed partial denture (bridge):
        - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, **or**

- The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics **or**
- Each abutment tooth to be crowned meets any limitations and exclusions.

b. Removable partial denture:
- Cast metal (D5213, D5214), one or more teeth are missing in an arch.
- Resin based (D5211, D5212), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease.

19. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.
20. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to:
    - The replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture **or**
    - The replacement of permanent tooth/teeth for Dependent children under 16 years of age.
21. Retained primary teeth shall be covered as primary teeth.
22. Excision of the frenum is a benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.
23. Benefits provided by a pediatric Dentist are limited to Dependent children through age seven following an attempt by the Contract Dentist to treat the child and upon prior Authorization by Us, less applicable Copayment(s). Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
24. In cases of accidental injury, benefits available are described in *Schedule A,* Accident Injury Damages. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function, exclusive attrition and normal wear, will be covered. Accident injury Benefits are limited to services provided as a result of an accident which occurred:
    - while You were covered under the Plan, or
    - while You were covered under another Plan, and if the Benefits for the expenses incurred would have been paid if You had remained covered under that Plan.

25. Benefits for a soft tissue management program are limited to those parts, which are listed covered services listed on *Schedule A*. If You declined non-covered services within a soft tissue management program, it does not eliminate or alter other covered benefits.

26. A new removable partial, complete or immediate denture includes after delivery adjustments and tissue conditioning, if needed, at no additional cost for the first six months after placement if You continue to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered. Immediate dentures and immediate removable partial dentures include after delivery adjustments and tissue conditioning at no additional cost for the first three months after placement.

27. An optional procedure is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by You, and is subject to the limitations and exclusions. The applicable charge is the difference between the Contract Dentist's submitted fee for the optional procedure and the submitted fee for the covered procedure, plus any applicable Copayment for the covered procedure.

28. When recommending covered crown(s), bridge pontic(s) and/or bridge retainers, which are supported either by a natural tooth or dental implant, Contract Dentists may offer services that utilize brand or trade names at an additional fee. You must be offered the Plan Benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If You choose the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed $150.00 in addition to the listed Copayment. Contact the Customer Service department at 800-422-4234 if You have questions regarding the additional fee or name brand services.

29. If any existing fixed bridge or removable denture that already replaces the tooth or teeth, which would be replaced by a new implant-supported prosthesis, that existing appliance must be eligible for replacement.

30. Replacement of implants and implant-supported prosthesis requires the existing implants and implant-supported prosthesis to be 5+ years old.
31. Implants and implant supported crowns and prosthesis are covered to replace one or more natural permanent teeth lost due to accidental trauma or removal.
32. Implant removal is limited to one (1) for each implant during Your lifetime.
33. Teledentistry services provided by a Dentist other than Your Contract Dentist are considered Out-of-Network and may result in an out-of-pocket cost to You.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Dental conditions arising out of and due to Your employment for which Worker's Compensation is paid. Services that are provided by state government or agency or are provided without cost by any municipality, county or other subdivision.
3. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
6. Dental expenses incurred in connection with any dental procedure started before Your eligibility with the Plan. Examples include: teeth prepared for crowns, root canals in progress, orthodontics, unless qualified for the orthodontic treatment in progress provision.
7. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.), except for the treatment of newborn children with congenital defects or birth abnormalities.
8. Dispensing of drugs not normally supplied in a dental facility.
9. Any procedure that in the professional opinion of the Contract Dentist or Our dental consultant:
    a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
    b. is inconsistent with generally accepted standards for dentistry.
10. Dental services received from any dental facility other than the Contract Dentist including the services of a dental specialist, unless expressly authorized by Us or as provided under Emergency Services. To obtain authorization, You should call the Customer Service department at 800-422-4234.
11. Consultations for non-covered Benefits.
12. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.

13. The replacement of lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and implant abutments, and fixed partial dentures (bridges) whether supported by a natural tooth or dental implant.

14. Procedures that may include:

    a. pre-implant diagnostic and therapeutic services, which are solely done to facilitate the placement of a dental implant including cone beam CT capture and interpretation, bone grafts and/or sinus augmentation;

    b. post-implant maintenance, osseous surgeries, bone grafts and/or regenerative procedures.

    c. removal of a dental implant and all other services associated with a dental implant, unless listed as a covered Benefit.

15. Implant and implant-supported crowns and appliances are not covered benefits for You or Dependent Enrollees under 19 years of age.

16. An implant-supported prosthesis with one abutment supported by a natural tooth and the second supported by an implant are not covered.

17. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

18. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ).

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

20. Procedures that may include:

    a. precious metal for removable appliances;

    b. metallic or permanent soft bases for complete dentures;

    c. porcelain denture teeth;

d. precision abutments for removable partials or fixed partial dentures including but not limited to overlays and related specialized appliances; and/or

e. personalization and characterization of complete and partial dentures.

21. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions.
22. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.
23. Treatment required by reason of war declared or undeclared.
24. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.
25. Accident injury Benefit exclusions include:
    - Prophylaxis.
    - Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
    - Orthodontic services (treatment of malalignment of teeth and/or jaws).
    - Replacement of existing restorations, crowns, bridges, dentures and other dental or orthodontic appliances damaged by accident injury.
    - Replacement of existing restorations due to decay.
26. TMJ Benefit exclusions include:
    - The replacement of lost, missing or stolen appliances furnished in whole or in part or any other TMJ Benefit.
    - Repair of any appliance furnished in whole or part.
    - Services which would normally be provided under medical care including, but not limited to, psychotherapy, special joint exams and x rays, joint surgery and medications.
    - Fixed appliances and restorations provided solely for the treatment of the TMJ.
    - Services for bruxism (grinding of teeth) unrelated to the TMJ.

Orthodontic Limitations

This Plan provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The start-up fees and the cost to You for the treatment plan are listed in *Schedule A* and subject to the following limitations:

1. Orthodontic treatment must be provided by a Contract Orthodontist.
2. Benefits cover 24 months of active comprehensive orthodontic treatment. Included is the initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustment to retainers and office visits for a maximum of two years.
3. Treatment plans extending beyond 24 months of active treatment, or 24 months of the retention phase of treatment will be subject to a monthly office visit fee to the Enrollee not to exceed $75.00 per month.
4. Should Your coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, You will be responsible for payment of any balance due for treatment provided after cancellation or termination. In such a case Your payment shall be based on a maximum of $2,800.00 for Dependent children to age 19 and $3,000.00 for Dependent Enrollees from age 19 to 25. The amount will be prorated over the number of months to completion of the treatment and, will be payable by You on such terms and conditions as are arranged between You and the Contract Orthodontist.
5. If treatment is not required or You choose not to start treatment after the diagnosis and consultation have been completed by the Contract Orthodontist, You will be charged a consultation fee of $25.00 in addition to diagnostic record fees.
6. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are Benefits. If any additional recementations or replacements of brackets/bands are performed, You are responsible for the cost at the Contract Orthodontist's submitted fees.

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

Orthodontic Exclusions

1. Pre-, mid- and post-treatment records that include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances.
3. Retreatment of orthodontic cases.
4. Changes in treatment necessitated by accident of any kind, and/or lack of Enrollee cooperation.
5. Surgical procedures incidental to orthodontic treatment.
6. Myofunctional therapy.
7. Surgical procedures related to cleft palate, micrognathia or macrognathia.
8. Treatment related to temporomandibular joint disturbances.
9. Supplemental appliances not routinely used in typical comprehensive orthodontics.
10. Restorative work caused by orthodontic treatment.
11. Phase I orthodontics, as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.
12. Extractions solely for the purpose of orthodontics.
13. Treatment in progress at inception of eligibility, unless qualified for the orthodontic treatment in progress provision.
14. Transfer after banding has been initiated.
15. Composite or ceramic brackets, lingual adaptation of orthodontic bands.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

DeltaCare USA
PO Box 1803 Alpharetta, GA 30023-1803
1-800-422-4234
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
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Toll Free
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