Delta Dental Individual & Family™

Delta Dental PPO™
Premium Plan for Families

Combined Policy and Disclosure Form **("Policy")**

***Provided by*:**

Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105

Administered by:

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023
888-282-8784 (TTY: 711)
deltadentalins.com

IENT-P-CORE-CA-R23

POLICY

You must elect to enroll any eligible person You wish to cover under this Policy. If an election is not made for an individual or dependent, such person will not be eligible under this Policy.

This dental plan is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company (collectively referred to as "Delta Dental"). Delta Dental will pay for Benefits as set forth in this Policy. This Policy is issued in exchange for payment of the first installment of Premium and on the basis of the statements made on Your application. It takes effect on the Effective Date You selected on Your application for coverage under this Plan. This Policy will remain in force unless otherwise terminated in accordance with the terms of this Policy or until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where You live.

READ THIS POLICY AND ITS ATTACHMENTS CAREFULLY

Our enrollment materials advise Enrollees that this Policy is available upon request, prior to enrollment, by contacting Our Customer Care. A matrix describing this Plan's major Benefits and coverages is included as *Attachment C, Information Concerning Benefits for Delta Dental Individual & Family* ("Attachment C"). You may obtain information about this Plan's coverage by calling Our Customer Care at **888-282-8784 (TTY: 711)**.

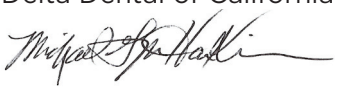
10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

If this Policy was solicited by deceptive advertising or negotiated by deceptive, misleading or untrue statements or if You are not satisfied, You may return this Policy within 10 days after You receive it. Mail or deliver it to Us. Any Premium paid will be refunded. This Policy will then be void from its start.

This Policy is issued and delivered in the state of California and is governed by its laws. If You move and no longer reside in the state of California, please call Our Customer Care at **888-282-8784**.

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

Delta Dental of California



Michael G. Hankinson, Esq.
Executive Vice President, Chief Legal Officer

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INTRODUCTION

We are pleased to welcome You to the Delta Dental Individual & Family PPO Plan ("Plan"). Our goal is to provide You with the highest quality dental care and to help You maintain good dental health. We encourage You not to wait until You have a problem to visit Your Dentist, but to visit one on a regular basis.

Using This Policy

This Policy, including Attachments, discloses the terms and conditions of Your coverage and is designed to help You make the most of Your dental plan. It will help You understand how this dental plan works and how to obtain dental care. Please read this Policy completely and carefully. Keep in mind that "You," "Your" and "Yourself" mean the Enrollees and/or Policyholder who are covered under this Policy. "We," "Us" and "Our" always refer to Delta Dental. In addition, please read the "Definitions" section as it will explain any words with special or technical meanings. Persons with Special Health Care Needs should read the "Special Health Care Needs" provision in this Policy.

Request Confidential Communications

You may request to receive communications about Your protected health information from Us at an alternate location or by an alternate method. If You would like to submit a new request for confidential communications or revise or cancel an existing one, **email it to departmentriskethicsandcompliance@delta.org, mail it to P.O. Box 997330 Sacramento, CA 95899-7330 or visit Our website. Your request will be valid until You cancel it or submit a new one.**

Contact Us

If You have any questions about Your coverage that are not answered in this Policy, visit Our website at **deltadentalins.com** or call Customer Care at **888-282-8784**. A representative can help with: answering questions about Your plan, explaining Benefits, locating a Delta Dental Provider, language assistance services, filing or checking the status of a claim or filing a grievance. You may also access Our automated information line at **888-282-8784** to obtain information about Your eligibility, Benefits or claim status. If You prefer to write to Us, please mail it to:

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

Identification Number

You should provide Your Enrollee identification ("ID") number to Your Delta Dental Provider whenever You receive dental services. Your ID number should be included on all claims submitted for payment. ID cards are not required but may be obtained by visiting Our website at **deltadentalins.com**.

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

DEFINITIONS

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

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

Administrator: Delta Dental Insurance Company or other entity designated by this Plan's underwriter, Delta Dental of California ("Delta Dental"), operating as administrator in the state of California. Certain functions described throughout this Policy may be performed by the administrator as designated by Us. The mailing address for the administrator is P.O. Box 1870, Alpharetta, GA 30023. The administrator will answer calls directed to **888-282-8784**. Also referred to as a Third Party Administrator or TPA

Benefits: the amounts that We will pay for covered dental services to Enrollees covered under this Plan.

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

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

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

Deductible: the dollar amount that an Enrollee must satisfy for certain covered services before We begin paying for Benefits.

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

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

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

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

Delta Dental Service Area: all geographic areas in the state of California in which We are licensed as a specialized health care service plan to offer this Plan.

Department of Managed Health Care: a department of the California Health and Human Services Agency who has charge of regulating specialized health care service plans. Also referred to as the "Department" or "DMHC."

Effective Date: the original date this Plan starts.

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

Eligible Primary: a resident of California who is legally able to enter into an agreement for coverage under this Plan.

Emergency Dental Condition: dental symptoms and/or pain that are so severe that a reasonable person would believe that, without immediate attention by a Provider, it could reasonably be expected to result in any of the following:

- placing the patient's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part; or
- death

Emergency Dental Service: dental screening, examination and evaluation by a Provider, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Provider, to determine if an Emergency Dental Condition exists and, if it does, the care, treatment and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Dental Condition, within the capability of the facility.

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

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

Generally Accepted Dental Practice Standards: treatment that is consistent with sound professional standards of dental practice in California for the dental condition in question.

Grace Period: the period of time beginning the day the *Notice of Start of Grace Period* is dated.

Maximum: the maximum dollar amount ("Maximum Amount" or "Maximum") We will pay toward the cost of dental care. You must satisfy costs above this amount. We will pay the Maximum Amount(s), if applicable, shown in *Attachment A* for Benefits covered under this Plan.

Maximum Contract Allowance: the reimbursement under Your Benefit plan against which We calculate Our payment and Your financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

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

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

Notice of End of Coverage: the notice sent by Us notifying You that Your coverage has been cancelled.

Notice of Start of Grace Period: the notice sent by Us notifying You that Your coverage will be cancelled unless the Premium amount due is received no later than the last day of the Grace Period.

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

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

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

Policyholder: the Primary Enrollee who enrolls for coverage under this Plan.

Premium: the amount You pay to Us as stated in the application or renewal notice for coverage under this Plan.

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

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

Provider: a person licensed to practice dentistry when and where services are performed. A provider also includes a dental partnership, dental professional corporation or dental clinic. Also referred to as a Dentist.

Qualifying Status Change:

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

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

Special Health Care Need: a physical or mental impairment, limitation or condition that substantially interferes with an Enrollee's ability to obtain Benefits. Examples of such a special health care need are: 1) the Enrollee's inability to obtain access to the Provider's facility because of a physical disability; and 2) the Enrollee's inability to comply with the Provider's instructions during examination or treatment because of physical disability or mental incapacity.

Spouse: a person related to or a domestic partner of the Policyholder as defined and as may be required to be treated as a spouse by the laws of the state where this Policy is issued and delivered.

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

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

We, Us and Our: Delta Dental

You, Your and Yourself: the individuals who are covered under this Plan.

ELIGIBILITY AND ENROLLMENT

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

Eligibility Requirements

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

- Dependents are the Policyholder's Spouse and eligible dependent children from birth to age 26.
- Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a Spouse.
- Dependent children 26 years of age and older may continue to be eligible if:

  (1) they are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and

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

  We will notify the Policyholder at least 90 days prior to the date the dependent child attains the limiting age that their coverage will terminate unless We receive proof of the criteria described above within 60 days of Your receipt of Our notification. Such requests will not be made more than once a year following a two (2) year period after this dependent child reaches the limiting age. Eligibility will continue as long as the dependent child relies on the Policyholder or Spouse for support and maintenance because of a physically or mentally disabling injury illness or condition.

Dependents on active military duty are not eligible.

Enrollment Period

Enrollees covered under this Plan must enroll for a minimum of 12 continuous months.

You have the right to terminate coverage under this Plan by providing Us written notice of cancellation. Your coverage and coverage for any enrolled Dependent Enrollees will terminate on the last day of the month that We receive Your request or the last day of the Policy Year, whichever comes first. If coverage is voluntarily discontinued, You are not eligible to re-enroll during the 12 month period immediately following Your voluntary termination.

A full refund of Premium is available if a written request for a refund is made within the first 10 days of the Effective Date. After that, all requests for a Premium refund will be pro-rated based upon the number of days remaining in the Policy Year if Premium has been paid in advance. However, a refund may not be available if You have received Benefits under this Policy.

PREMIUM PAYMENT RESPONSIBILITIES

Your Premium is determined by the plan design chosen at the time of enrollment and by the age of the Enrollees. You are responsible for making timely Premium payments and for paying a one-time non-refundable enrollment fee when submitting Your application for enrollment under this Plan. Premium amounts are listed in the application or renewal notice.

Prepayment Fees\Premiums

Each Premium is to be paid on or before the due date. The due date is the day following the last day of the period for which the preceding Premium was paid. You may pay Your Premium online by visiting Our website at **deltadentalins.com** or by mailing Your payment to:

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

Rate Guarantee

Your Premium rate is guaranteed for each Policy Year based upon the new Enrollee rates in force at the time of Your enrollment. However, the rate guarantee can be less than 12 months if You have an Effective Date mid-year due to a Qualifying Status Change or if an Enrollee reaches age 18 during a Policy Year. If an Enrollee reaches age 18 during a Policy Year, the new Premium becomes effective with the next invoice following the 18th birthday.

Unless there is a change in Premium due to age or due to Our liability being changed by law or regulation, no change in Premiums will become effective within a Policy Year. A change in law or regulation may include a state and/or federal mandated change or a new or increased tax, assessment or fee imposed on the amounts payable to, or by, Delta Dental under this Policy or any immediately preceding policy between Delta Dental and You. We would provide written notice to You and this Policy will then be modified on the date stated in the notice.

Changing Payment Options

Payment options may be changed at any time. The effective date of any change is the date of the next scheduled payment based on Your new billing period. You can change Your payment option by visiting Our website at **deltadentalins.com** or by calling Our Customer Care at **888-282-8784**.

RENEWAL

We will send You a renewal notice that includes any proposed changes in Benefits and/or Premium at least 30 days before Your coverage expires. Your coverage will terminate at the end of the Policy Year unless You renew by paying the applicable Premium on or before the date that Your Policy expires.

CANCELLATION, RESCISSION OR NON-RENEWAL OF COVERAGE

You may keep this Policy in force by making timely Premium payments. However, We may refuse renewal due to:

- Premiums not paid on or before the last day of the Grace Period. Please refer to the "Cancellation of Enrollment Due to Non-Payment of Premium" provision;
- You are no longer eligible under the terms of this Policy (termination in this case automatically occurs on the last day of the month in which You no longer meet eligibility requirements);
- Your moving out of the state in which this Policy was issued (if You move and no longer reside in the state of California, please call Our Customer Care at **888-282-8784**);
- fraud or an intentional misrepresentation of material fact when applying for this coverage or filing a claim for Benefits;
- Your failing to comply with material provisions of this Policy; or
- Our ceasing to renew all policies issued on this form to residents of the state where You live.

At least 30 days' advance written notice of any non-renewal action permitted by this provision will be mailed to the Policyholder at the last address shown in Our records. This notice will include the reason(s) why coverage is being terminated and the date that coverage will end. We will not pay for services received after coverage is terminated. However, We will pay for the completion of Single Procedures started while You were eligible if they are completed within 31 days of the date coverage ended.

If We fail to provide a 30-day advance written notice advising You of Our intent to terminate coverage, Your coverage will remain in effect until 30 days after notice is given or until the effective date of replacement coverage, whichever occurs first.

In the event of cancellation of enrollment by either Us (except in the case of fraud or deception in the use of services or facilities or knowingly permitting such fraud or deception by another) or You, We will within 30 days return to You the pro rata portion of the Premiums paid to Us which corresponds to any unexpired period for which payment had been received, together with any amounts due on claims, if any, less any amounts due to Us.

CANCELLATION OF ENROLLMENT

Cancellation of Enrollment Due to Non-Payment of Premium

Grace Period

If We do not receive Your Premium payment on or before the due date, Your account will be considered late. We will send You a *Notice of Start of Grace Period* advising that a payment delinquency has triggered a Grace Period beginning the day the *Notice of Start of Grace Period* is dated and that Your coverage will be terminated unless the full Premium amount due is received by Us on or before the last day of the Grace Period. This *Notice of Start of Grace Period* will include vital information needed to maintain uninterrupted coverage such as: an explanation of the Grace Period, the beginning and end dates of the Grace Period, the dollar amount past due, the date of the last day of paid coverage and a statement explaining the consequences of losing coverage.

Coverage will continue during the Grace Period. Coverage will also continue upon payment of all outstanding Premium amounts received any time before the expiration of the Grace Period. You are financially responsible for any and all Premiums, and any copayments, Enrollee Coinsurance or Deductible amounts, including those incurred for services received during the Grace Period.

If, after receiving the *Notice of Start of Grace Period*, Your account remains delinquent after the Grace Period expires, Your coverage will be terminated. We will then send You a *Notice of End of Coverage* within five (5) calendar days after the date coverage ends stating the effective date and reason for cancellation of coverage and whom to contact for assistance.

Cancellation of Enrollment for Other Than Non-Payment of Premium

For cancellation, rescission or non-renewal other than for non-payment of Premium, We will provide You with a *Notice of Cancellation, Rescission or Non-Renewal*. A *Notice of End of Coverage* will be provided to You for all cancellations after the date coverage has ended, but no later than five (5) calendar days after the date coverage has ended that includes the reason for cancellation and whom to contact for assistance.

If coverage is terminated for any cause, We are not required to preauthorize services beyond the termination date or to pay for services provided after the termination date, except for services begun while Your plan was in effect or if You have a cancellation grievance pending for reasons other than non-payment of Premium submitted prior to the effective date of Your cancellation, rescission or non-renewal. Please refer to the following section regarding Your right to submit a grievance.

Right to Submit a Grievance Regarding Cancellation, Rescission or Non-Renewal of Your Plan Enrollment, Subscription or Contract

If You believe Your enrollment has been, or will be, improperly cancelled, rescinded or not renewed, You have at least 180 days from the date of the notice You allege to be improper to submit a grievance to Us and/or the Department of Managed Health Care ("DMHC"). We will provide You and the DMHC with a disposition or pending status on Your grievance within three (3) calendar days of Our receipt of Your grievance.

For grievances submitted prior to the effective date of the cancellation, rescission or non-renewal for reasons other than non-payment of Premium, We will continue to provide coverage while the grievance is pending with Us or the DMHC. During the period of continued coverage, You are responsible for paying Premiums and any and all copayments, Enrollee Coinsurance or Deductible amounts as required under Your coverage.

OPTION 1 – YOU MAY SUBMIT A GRIEVANCE TO YOUR PLAN.

You may submit online at **deltadentalins.com**, or call **888-282-8784** or write to:

Delta Dental of California
Attn: Correspondence Department
P.O. Box 997330
Sacramento, CA 95899-7330

You may want to submit Your grievance to Us first if You believe Your cancellation, rescission or non-renewal is the result of a mistake. Grievances should be submitted as soon as possible.

We will resolve Your grievance or provide a pending status within three (3) calendar days. If You do not receive a response from Us within three (3) calendar days, or if You are not satisfied in any way with Our response, You may submit a grievance to the DMHC as detailed under Option 2 below.

OPTION 2 – YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DMHC.

You may submit a grievance to the DMHC without first submitting it to Us or after You have received Our decision on Your grievance. Grievances may be submitted to the DMHC online at **www.Healthhelp.ca.gov** or by mailing Your written grievance to:

Help Center
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725

You may contact the DMHC for more information on filing a grievance at:

Phone: 1-888-466-2219
TDD: 1-877-688-9891
Fax: 1-916-255-5241

Reinstatement of Coverage

If Your coverage is terminated due to non-payment of Premium and We accept payment of the proper Premiums after termination of this Policy without requiring a new application, We will reinstate this Policy as though it had never terminated unless We, within 20 business days of receipt of such payment, either: 1) refuse Your payment or 2) issue You a new policy accompanied by written notice clearly stating those aspects in which the new policy differs from this terminated Policy in Benefits, coverage or otherwise.

If You submit a grievance for cancellation, rescission or non-renewal of coverage, including cancellation due to non-payment of Premium, and it is determined that the cancellation is improper, Your coverage may be reinstated retroactive to the date of cancellation, rescission or non-renewal. You are responsible for paying any and all outstanding Premium amounts accrued from the effective date of the cancellation, rescission or non-renewal of coverage before reinstatement. Any outstanding Premium must be paid prior to reinstatement.

OVERVIEW OF DENTAL BENEFITS

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

Benefits, Limitations and Exclusions

This Plan provides Benefits using the Delta Dental PPO™ Network within the Delta Dental Service Area in the state of California during the Policy Year. We pay for Benefits described in the Attachments attached to this Policy.

This Policy covers several categories of dental services when received by a Delta Dental Provider and when they are necessary and within the standards of Generally Accepted Dental Practice Standards. Claims are processed in accordance with Our standard processing policies. The processing policies may be revised at the beginning of a Calendar Year to comply with annual CDT changes and processing made by the American Dental Association to reflect changes in Generally Accepted Dental Practice Standards. We will provide You at least 30 days' advance notice of such changes.

We use the processing policies that are in effect at the time the claim is processed. We may use Dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine Generally Accepted Dental Practice Standards and to determine if treatment has a favorable prognosis. If You receive dental services from a Provider outside the state of California, that Provider will be paid according to Our network payment provisions for that state and according to the terms of the Provider agreement.

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

A Benefit appropriately provided through Teledentistry is covered on the same basis and to the same extent that the Benefit is covered through in-person diagnosis, consultation or treatment. The fee for Teledentistry services is considered inclusive in overall patient management and is not a separately payable service.

Enrollee Coinsurance

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

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

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

Pre-Treatment Estimates

Pre-Treatment Estimate requests are not required; however, Your Provider may file a Claim Form before beginning treatment, showing the services to be provided to You. We will estimate the amount of Benefits payable under Your plan for the listed services. By asking Your Provider for a Pre-Treatment Estimate from Us before You receive any prescribed treatment, You will have an up-front estimate of what We will pay and the difference You will need to pay. The Benefits will be processed according to the terms of this Policy when the treatment is actually performed.

Pre-Treatment Estimates are valid for 365 days unless other services are received after the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:

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

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

Non-Covered Services

IMPORTANT: If You opt to receive dental services that are not covered services under this Plan, a participating Provider may charge You their usual and customary rate for those services. Prior to providing You with dental services that are not a covered Benefit, Your Provider should provide You with a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about Your dental coverage options, You may call Our Customer Care at **888-282-8784**. To fully understand Your coverage, You should carefully review this Policy.

Limitations and Exclusions

Dental plans are designed to help with part of Your dental expenses and may not always cover every dental need. The typical plan includes limitations and exclusions, meaning the plan does not cover every aspect of dental care. This can relate to the type of procedures or the number of visits. These limitations and exclusions are carefully detailed in Attachments A and B of this Policy and You should make Yourself familiar with them.

Covered Benefits

This Plan covers several categories of Benefits when a Delta Dental Provider provides the services and when they are within Generally Accepted Dental Practice Standards.

To help You understand the types of procedures that are included in each category, please carefully review *Attachment B* for the full description of each covered service's limitations and exclusions.

SELECTING YOUR PROVIDER

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

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

Free Choice of Provider

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

Locating a PPO Provider

You may access information through Our website at **deltadentalins.com** and then by selecting the Delta Dental PPO Network. You may also call Our Customer Care and one of Our representatives will assist You. We can provide You with information regarding a Provider's network participation, specialty and office location.

Choosing a PPO Provider

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

Choosing a Premier Provider

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

Choosing a Non-Delta Dental Provider

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

Additional Obligations of PPO and Premier Providers

- A PPO Provider and Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Us after satisfaction of the Deductible and Enrollee Coinsurance. You do not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- A PPO Provider and a Premier Provider will complete the dental Claim Form and submit it to Us for reimbursement.
- A PPO Provider will accept the PPO Provider's Contracted Fee as payment in full for covered services and will not balance bill if there is a difference between the Submitted Fees and the PPO Provider's Contracted Fees.
- By statute, Our agreement with Our PPO and Premier Providers ensures that You will not be responsible to those Providers for any money We owe.

Upon termination of a PPO Provider's agreement with Us, We will be liable for Benefits for the completion of treatment for Single Procedures that began prior to the termination of the agreement.

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

If You will be materially or adversely affected by the termination, breach of contract or the inability of a PPO Provider to perform, We will send You written notice within a reasonable amount of time.

Continuity of Care

If You are a current Enrollee, You may have the right to obtain completion of care under this Policy with Your terminated Delta Dental Provider for certain specified dental conditions. If You are a new Enrollee, You may have the right to completion of care under this Policy with Your Non-Delta Dental Provider for certain specified dental conditions. You must make a specific request for this completion of care Benefit. To make a request, contact Our Customer Care at **888-282-8784**. You may also contact Us to request a copy of Our *Continuity of Care Policy*. We are not required to continue care with Your Provider if You are not eligible under this Policy or if We cannot reach agreement with Your Non-Delta Dental Provider or terminated Delta Dental Provider on the terms regarding Enrollee care in accordance with California law.

Emergency Dental Services

PPO and Premier Providers are available 24 hours a day, 7 days a week to provide Emergency Dental Services if You are experiencing an Emergency Dental Condition. However, if You are unable to reach a PPO or Premier Provider, You may seek treatment from a dental Provider of Your choice. Payment for Emergency Dental Services will be made subject to the provisions described in this Policy. If You have an Emergency Dental Condition that requires an emergency response, please call **911**.

Timely Access to Care

PPO and Premier Providers have agreed waiting times to Enrollees for appointments for care which will never be greater than the following timeframes:

- for emergency care, 24 hours a day, 7 day days a week
- for any urgent care, 72 hours for appointments consistent with the Enrollee's individual needs
- for any non-urgent care, 36 business days
- for any preventive services, 40 business days

During non-business hours, You have access to a PPO or Premier Provider's answering machine, answering service, cell phone or pager for guidance on what to do and whom to contact for urgent dental services or if You are experiencing an Emergency Dental Condition including while outside of the Delta Dental Service Area.

If You call Our Customer Care, a representative will answer Your call within 10 minutes during normal business hours.

Language Assistance Services

We offer qualified interpretation services to limited-English proficient Enrollees, at no cost to the Enrollee, at all points of contact in any modern language including when an Enrollee is accompanied at the dental office by a family member or friend who can provide language interpretation services.

If You need language interpretation services, materials translated into Your preferred language or into an alternate format, please call **888-282-8784 (TTY: 711)**. You may also visit Our Provider Directory on Our website which includes self-reported languages by Our Delta Dental Providers.

Second Opinion

We obtain second opinions through Regional Consultant members of Our Quality Review Committee who conduct clinical examinations, prepare objective reports of dental conditions, and evaluate treatment that is proposed or has been provided.

We will authorize such an examination prior to treatment when necessary to make a benefits determination in response to a request for a Pre-Treatment Estimate. We will also authorize a second opinion after treatment if You have a complaint regarding the quality of the care provided. We will notify You and Your treating Provider when a second opinion is necessary and appropriate and direct You to a Regional Consultant selected by Us to perform the clinical examination. When We authorize a second opinion through a Regional Consultant, We will pay for all charges.

You may otherwise obtain second opinions about treatment from any dental Provider of Your choice. Claims for the examination may be submitted to Us for payment. We will pay such claims in accordance with the Benefits of this Plan.

Special Health Care Needs

If You believe You have a Special Health Care Need, You should call Customer Care at **888-282-8784 (TTY: 711)**. We will confirm that a Special Health Care Need exists and what arrangements can be made to assist You in obtaining Benefits. We will not be responsible for the failure of any Provider to comply with any law or regulation concerning structural office requirements that apply to a Delta Dental Provider treating Enrollees with Special Health Care Needs.

Facility Accessibility

Many dental facilities provide Us with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding dental facility accessibility, call Customer Care at **888-282-8784** or visit Our website at **deltadentalins.com**.

HOW CLAIMS ARE PAID

Payment by Us for any Single Procedure that is a covered service will be made upon completion of the procedure. Payment for care is applied to the Calendar Year Deductible and Maximum Benefit based on the date of service, regardless of when the claim is submitted. After You have satisfied Your Deductible requirement, We will pay for covered services at the percentage indicated in *Attachment A*, up to a Maximum for each Enrollee in each Calendar Year.

Payment Guidelines

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

If You or Your Provider file a claim for services more than 12 months after the date You received the services, payment may be denied. If the services were received from a Non-Delta Dental Provider, You are still responsible for the full cost. If We fail to pay a Non-Delta Dental Provider, You may be liable to that Provider for the entire cost of services. We will reimburse You for any portion of the Provider's fee that is covered by this Plan.

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

If You need more information concerning how Providers are reimbursed under this Plan, please contact Us.

How to Submit a Claim

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

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

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

Provider Relationships

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

GRIEVANCES AND APPEALS

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

Grievances regarding eligibility, the denial of dental services or claims, Our policies, procedures and operations or the quality of care for dental services performed by a Delta Dental Provider may be directed to Us by calling **888-282-8784 (TTY: 711)**, completing and submitting a **Delta Dental PPO Enrollee Grievance Form** online or mailing it to:

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

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

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

"Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or Provider, including quality of care concerns, and includes a complaint, dispute, request for reconsideration or appeal made by You or Your representative. Where We are unable to distinguish between a grievance and an inquiry, it will be considered a grievance.

"Complaint" is the same as "grievance."

"Complainant" is the same as "grievant" and means the person who filed the grievance including You, Your representative or other individual with authority to act on Your behalf.

Within five (5) calendar days of Our receipt of any complaint, a quality management coordinator will forward to You a written acknowledgment of Your grievance which will include the date of Our receipt and plan contact information. Certain complaints may require that You be referred to a Dentist for clinical evaluation of the dental services provided. We will forward to You a determination, in writing, within 30 calendar days of Our receipt of Your grievance.

Our grievance system ensures all plan Enrollees have access to and can fully participate in Our grievance process by providing assistance for those with limited-English proficiency or with visual or other communicative impairments. Such assistance includes, but is not limited to, translations of grievance procedures, forms and plan responses to grievances as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. If You are in need of these services and/or have questions about Our grievance process, please call Customer Care at **888-282-8784 (TTY: 711)** and/or visit Our website at **deltadentalins.com** to complete and submit a **Delta Dental PPO Enrollee Grievance Form** online.

Our grievance system allows Enrollees to file grievances for at least 180 calendar days following any incident or action that is the subject of an Enrollee's dissatisfaction. We do not discriminate against any Enrollee on the grounds that the complainant filed a grievance.

You may file a complaint with the DMHC after completing Our grievance process or if You have been involved in Our grievance process for more than 30 days. You may seek assistance or file a grievance immediately with the DMHC in cases involving an imminent and serious threat to their health including, but not limited to, severe pain, potential loss of life, limb or major bodily function. In such case, We will provide You and the DMHC with a disposition or pending status of Your grievance within three (3) calendar days of Our receipt of Your grievance. You may file a complaint with the DMHC immediately if You are experiencing an Emergency Dental Condition.

Complaints Involving an Adverse 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 this Policy, We will consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of the consulting Dentist will be available upon request. If You believe that the decision was denied on the grounds that it was not medically necessary, You may contact the DMHC to determine if the decision is eligible for an Independent Medical Review. You will not be discriminated against in any way by Us for filing a grievance.

California law requires that We provide You with the following information:

The CA Department of Managed Health Care is responsible for regulating health care service plans. If You have a grievance against Your health plan, You should first telephone Your health plan at **888-282-8784** and use Your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to You. If You need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Your health plan, or a grievance that has remained unresolved for more than 30 days, You may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If You are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

GENERAL PROVISIONS

Public Policy Participation by Enrollees

Our Board of Directors includes enrollees who participate in establishing Our public policy regarding enrollees through periodic review of Our Quality Assessment Program reports and communications from enrollees. You may submit any suggestions regarding Our public policy in writing to:

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

Entire Policy; Changes

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

Severability

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

Incontestability

We will not rescind or limit any provisions of this Policy once You are covered under this Plan unless We can demonstrate that You performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of this Policy. If We intend to rescind coverage by demonstrating the aforementioned, We will send You a notice at least 31 days prior to the effective date of the rescission explaining the reason(s) for rescinding coverage and informing You of Your right to appeal this rescission with the director of the DMHC.

After 24 months following the issuance of this Policy, We will not rescind this Policy for any reason. We will not cancel or limit any provisions of this Policy or raise Premiums due to any omissions, misrepresentations or inaccuracies in the application form, whether willful or not.

Clinical Examination

Before approving a claim, We will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider or from hospitals in which a Provider's care is provided, such information and records relating to the attendance to or examination of, or treatment provided to You as may be required to administer the claim. Examination may be required by a dental consultant retained by Us in or near Your community or residence. We will, in every case, hold such information and records confidential.

Written Notice of Claim/Proof of Loss

We must be given written claim or proof of loss within 12 months after the date of service or loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give written proof in the time required provided that the proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated). A notice of claim submitted by You, on Your behalf, or on behalf of Your beneficiary to Us or to Our authorized agent, with information sufficient to identify You will be considered notice of claim.

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

Send Your Notice of Claim/Proof of Loss to Us at:

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

Notice of Claim Form

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

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

Time of Payment

Claims payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be processed no later than 30 days after written proof of loss is received in the form required by the terms of this Policy. We will notify You and Your Provider of any additional information needed to process the claim within this 30-day period.

To Whom Benefits Are Paid

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

Misstatements on Application; Effect

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

If any misstatement, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the facts been known to Us, would not in good faith have issued this Policy at the same Premium rate. If any misstatement would materially affect the rates, We reserve the right to adjust the Premium to reflect Your actual circumstances at the time of application.

Legal Actions

No action at law or in equity will be brought to recover on this Policy prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of this Policy. No action can be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by this Policy.

Conformity with Applicable Laws

All legal questions about this Policy will be governed by the state of California where this Policy was entered into and is to be performed. Any part of this Policy that conflicts with the laws of California, specifically Chapter 2.2 of Division 2 of the California Health and Safety Code and Chapter 1 of Division 1, of Title 28 of the California Code of Regulations, or federal law is hereby amended to conform to the minimum requirements of such laws. Any provision required to be in this Policy by either of the above will bind Us whether or not provided in this Policy.

Holding Company

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

Third Party Administrator ("TPA")

We may use the services of a TPA, duly registered under applicable state law, to provide services under this Policy. Any TPA providing such services or receiving such information will enter into a separate business associate agreement with Us providing that the TPA meets HIPAA and HITECH requirements for the preservation of protected health information of enrollees.

Organ and Tissue Donation

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

Impossibility of Performance

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

Non-Discrimination

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.

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, call Our Customer Care at **888-282-8784 (TTY: 711)**.

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 Care representative or by mail:

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
Telephone Number: **888-282-8784 (TTY: 711)**
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, DC 20201
1-800-368-1019
1-800-537-7697 (TDD)

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

Attachment A
Deductibles, Maximums and Policy Benefit Levels

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

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

[1] Annual Deductible applies to all service categories except Diagnostic and Preventive Services. Benefits will apply after the annual Deductible is satisfied.

[2] We will pay or otherwise discharge the Policy Benefit Levels according to the Maximum Contract Allowance for covered services.

Note: While We will pay the same Policy Benefit Levels for covered services performed by a PPO Provider, Premier Provider and a Non-Delta Dental Provider, the amount charged to You for covered services performed by a Premier Provider or Non-Delta Dental Provider may be above that accepted by PPO Providers and You will be responsible for balance-billed amounts.

[3] Benefit Waiting Period is calculated for each Primary Enrollee and/or Dependent Enrollee from their own Effective Date of coverage. The 6-month Benefit Waiting Period for Basic Services, Major Services and Orthodontic Services will be waived upon Your proof of prior comparable dental coverage. This Benefit Waiting Period will be pro-rated on a one to one monthly basis upon Your proof of prior comparable dental coverage of less than 6 months.

We will determine acceptable documentation to verify prior proof of coverage. We will also determine the maximum allowable gap in coverage before pro-ration of the Benefit Waiting Period would no longer occur. Dental services obtained via a discount health plan are not considered "comparable" dental coverage for purposes of counting towards the Benefit Waiting Period.

Attachment B
Services, Limitations and Exclusions

Description of Dental Services

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

- **Diagnostic and Preventive Services**

(1) Diagnostic: Procedures to assist Providers in evaluating the existing conditions to determine the required dental treatment such as oral examinations (including initial examinations, periodic examinations and emergency examinations); x-rays; diagnostic casts; and biopsy of oral tissue

(2) Preventive: Procedures to prevent the occurrence of disease. These services include cleaning, topical application of fluoride solutions and space maintainers when used to maintain existing space. Prophylaxes and/or periodontal maintenance cleanings (periodontal maintenance is considered to be a Basic Benefit for payment purposes) may be performed either together or separately.

(3) Sealants: Topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

- **Basic Services**

(1) Palliative: Emergency treatment to relieve pain.

(2) Restorative: Services include amalgam and resin-based composite restorations (fillings) and prefabricated crowns for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

(3) Specialist Consultations: Opinion or advice requested by a general Dentist.

- **Major Services**

(1) Crowns and Inlays/Onlays: Services include single crowns, inlays and onlays, gold or cast restorations when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations.

(2) Prosthodontics: Services include materials and procedures for construction of fixed bridges, partial or complete dentures, pontics, and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation. Services for implants include procedures for endodontic endosseous, endosteal, eposteal and transosteal implants; implant connecting bars and implant repairs.

(3) Oral Surgery: Services include oral surgery procedures (including, but not limited to, reduction of fractures, removal of tumors, and removal of impacted teeth) including pre- and post-operative care.

(4) Endodontics: Services for treatment of the tooth pulp including pulpal therapy and root canal filling.

(5) Periodontics: Treatment of disease of the gums and bones supporting teeth.

(6) General Anesthesia or IV Sedation: When administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.

(7) Denture Repairs: Services include repair of broken, complete or partial dentures; repair or replacement of broken teeth on dentures; reattachment, replacement or repair of broken clasps on dentures including rebase procedures; and relining of complete or partial dentures performed at a Provider's office or by a laboratory. Includes denture repair and relining services which will make an existing denture fit satisfactorily.

- **Orthodontic Services**

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

- ***Note on additional Benefits during pregnancy***

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

Limitations

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

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

Examples of Optional Services:

a) a composite restoration instead of an amalgam restoration on posterior teeth;

b) a crown where a filling would restore the tooth;

c) an Inlay/Onlay instead of an amalgam restoration;

d) porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown); or

e) an overdenture instead of denture.

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

(2) Exam and cleaning limitations:

a) We will pay for oral examinations (except after-hours exams and exams for observation) and cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (including periodontal maintenance or any combination thereof) no more than twice in a Calendar Year.

b) A full mouth debridement is allowed once in a lifetime, when You have no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three years, and counts toward the cleaning frequency in the year provided.

c) Note that periodontal maintenance, Procedures Codes that include periodontal maintenance and full mouth debridement are covered as a Basic Benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.

d) Caries risk assessments are allowed once in 12 months.

e) Full mouth debridement is not allowed when performed by the same Provider/Provider's office on the same day as evaluation procedures.

(3) X-ray limitations:

a) We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intra-oral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intra-oral series.

b) When a panoramic film is submitted with supplemental film(s), We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intra-oral series.

c) If a panoramic film is taken in conjunction with an intra-oral complete series, We consider the panoramic film to be included in the complete series.

d) A complete intra-oral series and panoramic film are each limited to once every 60 months.

e) Bitewing x-rays are limited to two (2) times in a Calendar Year when provided to Enrollees under age 18 and one (1) time each Calendar Year for Enrollees age 18 and over. Bitewings of any type are not billable to the patient within 12 months of a full mouth series unless warranted by special circumstances.

f) Bitewing x-rays are limited to two (2) images for Enrollees under age 10.

g) Image capture procedures are not separately allowable services.

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

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

(6) Space maintainer limitations:

a) Except for distal shoe space maintainers, space maintainers are limited to the initial appliance and are a Benefit for an Enrollee to age 14.

b) A distal shoe space maintainer - fixed – unilateral is limited to children 8 and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.

c) Recementation of space maintainer is limited to once per lifetime.

d) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

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

(8) Cephalometric x-rays, oral/facial photographic images and diagnostic casts are covered once per lifetime in conjunction with Orthodontic Services only when Orthodontic Services are a covered Benefit. If Orthodontic Services are covered, see Limitations as age limits may apply. However, 3D x-rays are not a covered Benefit.

(9) Sealants are limited as follows:

a) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without caries (decay) or restorations on the occlusal surface.

b) repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement.

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

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

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

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

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

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

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

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

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

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

(20) Periodontal limitations:

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

b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same Provider/Provider's office.

c) Periodontal Services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.

d) Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.

e) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.

f) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider/Provider's office.

g) When implant procedures are a covered Benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a basic Benefit and are limited to once in a 24-month period.

(21) Oral Surgery procedures are limited to once per lifetime, per tooth or per quadrant as applicable. Removal of cysts and lesions, and incision and drainage procedures, are not limited to once per lifetime and will be covered once in the same day. An exception will be made based on medical necessity in the event that an Oral Surgery procedure needs to be repeated.

(22) Crowns and Inlays/Onlays are limited to Enrollees aged 12 and older and are covered not more often than once in any 60 month period except when We determine the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

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

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

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

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

(27) Prosthodontic appliances implants and/or implant supported prosthetics that were provided under Our Plan will be replaced only after 60 months have passed, except when We determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Implants and/or implant supported prosthetics are limited to Enrollees age 19 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under Our Plan will be made if We determine it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Our payment for implant removal is limited to one (1) for each implant in 60 months whether provided under Us or any other dental care plan.

(28) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(29) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider's office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider's office.

(30) We limit payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six (6) months after placement.

a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.

b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period.

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

d) Recementation of fixed partial dentures is limited to once in a lifetime.

(31) Limitations on Orthodontic Services:

a) The maximum amount payable for each Enrollee is shown in *Attachment A*.

b) Benefits for Orthodontic Services will be provided in periodic payments based on Your continuing eligibility.

c) Benefits are not paid to repair or replace any orthodontic appliance received under this plan.

d) Benefits are not paid for orthodontic retreatment procedures.

e) Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics is not a covered Benefit.

f) The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.

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

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

(34) Limitations on Occlusal Guard Services:

a) Occlusal Guards are limited to one (1) in a 60-month period.

b) After six (6) months from initial placement, Occlusal Guard repair or relining will be limited to one (1) in a 24-month period.

c) After six (6) months from initial placement, Occlusal Guard adjustments will be limited to one (1) in a 12-month period.

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

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

Exclusions

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

We do not pay Benefits for:

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

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

(3) Maxillofacial prosthetics.

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

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

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

(7) Any Single Procedure provided prior to the date You became eligible for services under this Plan.

(8) Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(9) Charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery [or selected Endodontic and Periodontal surgical] procedures. Local anesthesia and regional/or trigeminal block anesthesia are not separately payable procedures.

(10) Extra-oral grafts (grafting of tissues from outside the mouth to oral tissues).

(11) Laboratory processed crowns for Enrollees under age 12.

(12) Fixed bridges and removable partials for Enrollees under age 16.

(13) Interim implants, endodontic endosseous implant and extra-oral implants.

(14) Indirectly fabricated resin-based Inlays/Onlays.

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

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

(17) Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments.

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

(19) Procedures not meeting Generally Accepted Dental Practice Standards on a dental consultant's professional review of the submitted documentation.

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

(21) Deductibles, amounts over plan maximums and/or any service not covered under this Plan.

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

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

(24) Missed and/or cancelled appointments.

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

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

(27) Dental case management motivational interviewing and patient education to improve oral health literacy.

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

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

(30) Diabetes testing.

(31) Corticotomy (specialized oral surgery procedure associated with orthodontics).

(32) Antigen or antibody testing.

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

Attachment C

Information Concerning Benefits for Delta Dental Individual & Family™

Delta Dental PPO™
Premium Plan for Families

THIS MATRIX IS INTENDED TO BE USED TO COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE COMBINED POLICY AND DISCLOSURE FORM SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PLAN BENEFITS AND LIMITATIONS.

(A) Annual Deductible[1]	$50 per Enrollee each Calendar Year $150 per family each Calendar Year
Deductible waived for	Diagnostic and Preventive Services
Orthodontic Deductible	$50 per Enrollee each Calendar Year
(B) Annual Maximum **Orthodontic Maximum**	$2,000 per Enrollee each Calendar Year $1,500 per Enrollee per lifetime

Policy Benefit Levels		
(C) Professional Services **Dental Service Category:**	**Delta Dental PPO Providers[2]**	**Delta Dental Premier and Non-Delta Dental Providers[2]**
Diagnostic and Preventive Services[1]	100%	100%
Basic Services[3]	80%	80%
Major Services[3]	50%	50%
Orthodontic Services[3]	50%	50%
(D) Outpatient Services	Not Covered	
(E) Hospitalization Services	Not Covered	
(F) Emergency Dental Coverage	Benefits for Emergency Dental Services by a Non-Delta Dental Provider are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.	

(G) Ambulance Services	Not Covered
(H) Prescription Drug Coverage	Not Covered
(I) Durable Medical Equipment	Not Covered
(J) Mental Health Services	Not Covered
(K) Chemical Dependency Services	Not Covered
(L) Home Health Services	Not Covered
(M) Other	Not Covered

[1] Annual Deductible applies to all service categories except Diagnostic and Preventive Services. Benefits will apply after the annual Deductible is satisfied.

[2] We will pay or otherwise discharge the Policy Benefit Levels according to the Maximum Contract Allowance for covered services.

Note: While We will pay the same Policy Benefit Levels for covered services performed by a PPO Provider, Premier Provider and a Non-Delta Dental Provider, the amount charged to You for covered services performed by a Premier Provider or Non-Delta Dental Provider may be above that accepted by PPO Providers and You will be responsible for balance-billed amounts.

[3] Benefit Waiting Period is calculated for each Primary Enrollee and/or Dependent Enrollee from their own Effective Date of coverage. The 6-month Benefit Waiting Period for Basic Services, Major Services and Orthodontic Services will be waived upon Your proof of prior comparable dental coverage. This Benefit Waiting Period will be pro-rated on a one to one monthly basis upon Your proof of prior comparable dental coverage of less than 6 months.

We will determine acceptable documentation to verify prior proof of coverage. We will also determine the maximum allowable gap in coverage before pro-ration of the Benefit Waiting Period would no longer occur. Dental services obtained via a discount health plan are not considered "comparable" dental coverage for purposes of counting towards the Benefit Waiting Period.

HIPAA Notice of Privacy Practices

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

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

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

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

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

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

PERMITTED USES AND DISCLOSURES OF YOUR PHI

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

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

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

Permitted uses and disclosures without an authorization

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

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

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

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

Disclosures made with your authorization

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

YOUR RIGHTS REGARDING PHI

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

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

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

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

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

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

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

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

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

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

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

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

CONTACTS

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

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330

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

Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call 888-282-8784 (TTY: 711).

¿Puede leer este documento? Si no, podemos encontrar a alguien que lo ayude a leerlo. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 888-282-8784 (servicio de retransmisión TTY deben llamar al 711). (Spanish)

您能自行閱讀本文件嗎？如果不能，我們可請人幫助您閱讀。您還可以請人以您的語言撰寫本文件。如需免費幫助，請致電 888-282-8784 (TTY: 711)。(Chinese)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 888-282-8784 (TTY: 711). (Tagalog)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 888-282-8784 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수 있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 888-282-8784 (TTY: 711)번으로 연락하십시오. (Korean)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 888-282-8784 (TTY՝ 711): (Armenian)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخواهیم تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 888-282-8784 (TTY: 711). (Persian Farsi)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نوفر لك من يساعدك في قراءتها. ربما يمكنك أيضًا الحصول على هذا المستند مكتوبًا بلغتك للمساعدة المجانية اتصل بـ 888-282-8784 (TTY: 711). (Arabic)

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 888-282-8784 (телетайп: 711). (Russian)

क्या आप इस दस्तावेज़ को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी सहायता करने हेतु किसी की व्यवस्था कर सकते हैं। आप इस दस्तावेज़ को अपनी भाषा में लिखा हुआ भी प्राप्त कर सकते हैं। निशुल्क सहायता के लिए, कृपया यहाँ कॉल करें 888-282-8784 (TTY: 711)। (Hindi)

この文書をお読みになれますか?お読みになれない場合には音読ボランティアを手配させていただきます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、 888-282-8784 (TTY: 711) までお問い合わせください。(Japanese)

ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 888-282-8784 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 888-282-8784 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ, សូមទូរស័ព្ទទៅ 888-282-8784 (TTY: 711)។ (Cambodian)

คุณสามารถอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย รับความช่วยเหลือฟรีได้โดยโทรไปที่ 888-282-8784 (TTY: 711) (Thai)

Non-Discrimination Disclosure

Discrimination is Against the Law

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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ENROLLEE NOTICES

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

Federal Notices:

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

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

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

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

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

State Notices:

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

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

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

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

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

Delta Dental
PO Box 997330
Sacramento, CA 95899-7330