EMPLOYEE BENEFIT BOOKLET

PLEASANTON UNIFIED SCHOOL DISTRICT

deltadentalins.com

Group: 06505

Divisions: 00024, 00030 and 09018

Effective Date: October 1, 2024

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Attachments

INTRODUCTION

We are pleased to welcome you to the group dental plan for **Pleasanton Unified School District**. Your plan is self-funded by your employer and your claims are administered by Delta Dental. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the Provider, but to see him/her on a regular basis.

This Employee Benefit Booklet is a summary of your group dental program. Please read it carefully. It only summarizes the detailed provisions of the group dental contract issued by Delta Dental of California ("Delta Dental") and cannot modify the Contract in any way.

Using This Employee Benefit Booklet

This Employee Benefit Booklet, which includes Attachment A, Deductibles, Maximums and Contract Benefit Levels (Attachment A) and Attachment B, Services, Limitations and Exclusions (Attachment B), Attachment C, Smileway Benefits (Attachment C) discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the plan works and how to obtain dental care. Please read this booklet completely and carefully. Keep in mind that "you" and "your" mean the individuals who are covered. "We," "us" and "our" always refer to Delta Dental. In addition, please read the Definitions section, which will explain any words that have special or technical meanings under the Contract.

The benefit explanations contained in this booklet are subject to all provisions of the Contract on file with your employer, trust fund, or other entity ("Contractholder") and do not modify the terms and conditions of the Contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet. This booklet is *not* a Summary Plan Description.

Notice: *This booklet is a summary of your group dental plan and must be in effect at the time covered dental services are provided. This information is not a guarantee of covered benefits, services or payments.*

Contact Us

For more information please visit our website at deltadentalins.com or call our Customer Service Center. A Customer Service Representative can answer questions you may have about obtaining dental care, help you locate a Delta Dental Provider, explain benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at 888-335-8227 during regular business hours to obtain information about Enrollee eligibility and benefits, group benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write us with your question(s), please mail your inquiry to the following address:

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

DEFINITIONS

Terms when capitalized in your Employee Benefit Booklet have defined meanings, given in the section below or throughout the booklet sections.

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

Benefits: covered dental services provided under the terms of the Contract.

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 Pre-Treatment Estimate.

Contract: the agreement between Delta Dental and the Contractholder, including any attachments.

Contract Benefit Level: the percentage of the Maximum Contract Allowance that Delta Dental will pay after the Deductible has been satisfied as shown in Attachment A.

Contractholder: the employer, union or other organization or group as named herein contracting to obtain Benefits.

Days: any mention of "days" in this Employee Benefit Booklet shall be calendar days unless defined otherwise.

Deductible: a dollar amount that an Enrollee and/or the Enrollee's family (for family coverage) must pay for certain covered services before Delta Dental begins paying Benefits.

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

Delta Dental Premier Contracted Fee: the fee for a Single Procedure covered under the Contract that a Premier Provider has contractually agreed to accept as payment in full for covered services.

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

Delta Dental PPO Contracted Fee: the fee for a Single Procedure covered under the contract that a PPO Provider has contractually agreed to accept as payment in full for covered services.

Dependent Enrollee: an Eligible Dependent enrolled to receive Benefits.

Effective Date: the original date the Contract starts. This date is given on this booklet's cover and Attachment A.

Eligible Dependent: a dependent of an Eligible Employee eligible for Benefits.

Eligible Employee: any employee as eligible for Benefits.

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

Enrollee Pays: 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.

Enrollee's Effective Date of Coverage: the date the Contractholder reports coverage will begin for each Primary Enrollee and each Dependent Enrollee.

Maximum: is the maximum dollar amount ("Maximum Amount" or "Maximum") Delta Dental will pay toward the cost of dental care. Enrollees must satisfy costs above this amount. Delta Dental will pay the Maximum Amount(s), if applicable, shown in Attachment A for Benefits under the Contract.

Maximum Contract Allowance: the reimbursement under the Enrollee's benefit plan against which Delta Dental calculates its payment and the Enrollee's 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 Provider's Submitted Fee or the Delta Dental PPO Contracted Fee.
- by a Premier Provider is the lesser of the Provider's Submitted Fee or the Delta Dental Premier Contracted Fee.
- by a Non-Delta Dental Provider is the lesser of the Provider's Submitted Fee or the Program Allowance.

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

Open Enrollment Period: the month of the year during which employees may change coverage for the next Contract Year.

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

Primary Enrollee: an Eligible Employee enrolled in the plan to receive Benefits; may also be referred to as "Enrollee".

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

Program Allowance: the maximum amount Delta Dental will reimburse for a covered procedure. Delta Dental sets the Program Allowance for each procedure through a review of proprietary data by geographic area. The Program Allowance may vary by the contracting status of the Provider and/or the Program Allowance selected by the Contractholder.

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

Qualifying Status Change: a change in:

- 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);
- employment status (change in employment status of Enrollee or Eligible Dependent);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee, dependent Spouse or child moves);
- a court order requiring dependent coverage; or
- any other current or future election changes permitted by Internal Revenue Code Section 125.

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

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

- as defined and as may be required to be treated as a Spouse by the laws of the state where the Contract is issued and delivered;
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides; and
- as may be recognized by the Contractholder.

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

COST OF COVERAGE

You are required to contribute towards the cost of your coverage.

You are required to contribute towards the cost of your Dependent Enrollee's coverage.

We may cancel the Contract 30 days after written notice to the Contractholder if the cost of coverage is not paid when due.

ELIGIBILITY AND ENROLLMENT

Eligibility Requirements

All part-time classified employees who work at least six hours per day are required to enroll and are eligible to receive 75% of the Benefits provided for full-time classified employees.

Part-time certificated employees are also eligible for this plan.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents.

- Dependents are the Primary Enrollee's legal Spouse or Domestic Partner (as defined below), and dependent children from birth to age 26.
- Children include natural children, stepchildren, foster children, children of a domestic partner, adopted children and children placed for adoption. The dependents of Primary Enrollees are eligible to enroll on the same date that the employee, of whom they are a Dependent, becomes a Primary Enrollee. Later-acquired dependents become eligible as soon as they acquire dependent status.
- A dependent child may continue eligibility if:
  a) He or she is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that began prior to reaching the limiting age;
  b) He or she is chiefly dependent on the eligible employee for support; and
  c) Proof of Dependent's disability is provided within 60 days of request. Such requests will not be made more than once a year following a two-year period after this Dependent reaches the limiting age. Eligibility will continue as long as the Dependent relies on the eligible employee for support because of a physically or mentally disabling injury, illness or condition that began before he or she reached the limiting age.
- Domestic partners are defined as same sex partners, who are both at least 18 years of age and opposite sex partners when one or both partners are over the age of 62. You may be required to provide your employer with a copy of the Declaration of Domestic Partnership registered with the Secretary of State of the State of California.

  Domestic partners of the opposite sex when both are under age 62 may not register a partnership with the Secretary of State. However, if your dental plan extends coverage to such partners, an affidavit of opposite sex domestic partnerships under age 62 may be required.

  A domestic partner is subject to the same terms and conditions as any other Dependent enrolled under this plan.

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

Dependents serving active military duty are not eligible, as they are typically covered under health and dental coverage provided by the military while they are on active duty.

Enrolling Your Dependents

Your Dependents must be enrolled when you first become eligible or on the first day of the month after they become Dependents.

Enrollment Requirements

If you are paying all or a portion of the coverage for yourself or your dependents then:

- You must enroll within 31 days after the date you become eligible or during an Open Enrollment Period.
- All dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period.
- If you elect dependent coverage, you must enroll all of your Dependent Enrollees for coverage.
- You must pay the cost of coverage in the manner elected by the Contractholder and approved by us. Coverage cannot be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Status Change.
- If you pay the cost of coverage for your Dependent Enrollees, you must pay in the manner elected by the Contractholder and approved by us until your dependents are no longer eligible or until you choose to drop dependent coverage. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.

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

Transferring from one school incentive plan to another

If you transfer from one school or school district's incentive plan to another incentive plan provided by a school or school district, your Benefits and annual Maximum may be affected in the following ways:

If there is a break in coverage between the two plans, the applicable percentage for Basic Benefits starts at 52.5%. But you and your Dependents qualify for the full annual Maximum provided under your current plan. The amounts paid under your previous plan do not reduce the annual Maximum paid under your current plan.

If there is no break in coverage between the two plans, you retain the applicable percentage for Basic Benefits you reached under your prior plan. But you do not qualify for any additional Maximum Amounts. The Maximum Amount your dental plan pays in a Calendar Year under both plans will not exceed the amount paid under your current plan.

Your dental history with Delta Dental moves with you when you transfer from one school's incentive plan to another incentive plan provided by a school or school district. For example if both plans cover two cleanings in a calendar year and you transfer from one plan to another, you do not qualify for four cleanings in a Calendar Year.

Transfer to another district

If you and your Dependents transfer to another School District that has the same Delta Dental plan, your percentage share of the bill for dental services will remain the same, as long as there is no break (month(s) in which you are ineligible) in coverage during the transition.

Approved Leave of Absence

If you go on an approved leave of absence, you may continue your coverage for yourself and your Dependents for a maximum of one year by paying the School District each month for the coverage. Your School District's administrative office can tell you how much the continued coverage will cost.

Coverage is reinstated on the day employment is resumed for Enrollees that are members of the National Guard or a military reserve unit absent from work due to active military duty. Any waiting period applied as a result of an Enrollee's absence from active employment due to service in the National Guard or military reserve unit shall be waived.

Family and Medical Leave of 1993

You can continue your coverage if you take a leave governed by the Family and Medical Leave Act of 1993. If you do not continue your coverage during the governed leave, it will be reinstated at the same Benefit level you received before your leave.

Uniformed Services Employment and Re-employment Rights Act of 1994

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

Labor Dispute

If you stop working because of a labor dispute (a strike, for example), you can continue your coverage for up to six months from the date you stopped work, as long as at least 75% of the absent employees at your workplace choose to keep their coverage for themselves and their Dependents. If you choose this option, you must make the appropriate monthly payment to the School District or your employee association.

If you lose eligibility because of a labor dispute, and then return to work, your eligibility will begin again on the first day of the month following your return to work. Your coverage will then be the same as that for a new employee, unless the School District makes retroactive payment (payment for past months that you were not working) for all employees who would have been eligible except for the labor dispute. These employees' future coverage would then be the same as if

there had been no break in eligibility. However, any services that were provided to these employees and their Dependents during the time they were not eligible would not be covered.

Loss of Eligibility

Your coverage ends on the earlier of (1) the last day of the month you stop working for the Contractholder, (2) are no longer an Eligible Employee of the Contractholder (3) are on strike, layoff or leave of absence or (4) immediately when the Contract ends. Your Spouse loses coverage when your coverage ends or when dependent status is lost. Your dependent children lose coverage when your coverage ends or the last day of the month when dependent status is lost.

Continuation of Benefits

We will not pay for any services/treatment received after your coverage ends. However, we will pay for covered services incurred while you were eligible if the procedures were completed within 31 days of the date your coverage ended.

A dental service is incurred:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED

We will pay Benefits for the dental services described in Attachment B. We will pay Benefits only for covered services. The Contract covers several categories of dental services when a Provider provides them and when they are necessary and within the standards of generally accepted dental practice standards. Claims will be processed in accordance with our standard processing policies. The processing policies may be revised at the beginning of a Calendar Year to comply with annual CDT changes made by the American Dental Association and to reflect changes in generally accepted dental practice standards. Delta Dental will provide advance notice of such changes to the Contractholder who will then distribute to Primary Enrollees.

We will use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and Exclusions will be applied for the period the person is an Enrollee under any Delta Dental program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional eligibility periods, if any, are listed in Attachment A. If you receive dental services from a Provider outside the state of California, the Provider will be paid according to Delta Dental's network payment provisions for said state according to the terms of the Contract.

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 the Contract. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, as shown in Attachment A and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Enrollee Coinsurance") and is part of your out-of-pocket cost. You pay this even after a Deductible has been met.

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider providing the service (see section titled "Selecting Your Provider"). Providers are required to collect Enrollee Coinsurance for covered services. Your group has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the Contractholder and Enrollees. 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 section titled "Selecting Your Provider" for more information.

Deductible

Your dental plan features a Deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The Deductible amounts are listed in Attachment A. Deductibles apply to all benefits unless otherwise noted. Only the Provider's fees you pay for covered Benefits will count toward the Deductible.

Maximum Amount

Most dental plans have a Maximum Amount. A Maximum Amount is the maximum dollar amount we will pay toward the cost of dental care. You are responsible for paying costs above this amount. The Maximum Amount payable is shown in Attachment A. Maximums may apply on a yearly basis, a per services basis, or a lifetime basis.

Pre-Treatment Estimate

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 the Contract for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before you agree to receive any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of the Contract 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 the Contract terminates;
- the date Benefits under the Contract are amended if the services in the Pre-Treatment Estimate are part of the amendment;
- the date your coverage ends; or
- the date the Provider's agreement with Delta Dental ends.

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

Coordination of Benefits

We coordinate the Benefits under the Contract with an Enrollee's benefits under any other group or pre-paid plan or Benefit plan designed to fully integrate with other policies. If this plan is the "primary" plan, we will not reduce Benefits. If this plan is the "secondary" plan, we may reduce Benefits otherwise payable under the Contract so that the total benefits paid or provided by all plans do not exceed 100 percent of total allowable expense.

- How do we determine which plan is the "primary" program?
  (1) The plan covering you as an employee is primary over a plan covering you as a dependent.
  (2) The plan covering you as an employee is primary over a plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    a) secondary to the plan covering the insured person as a dependent and
    b) primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.
  (3) Except as stated below, when this plan and another plan cover the same child as a dependent of different persons, called parents:
    a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but
    b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(4) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.

(5) If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in (3) a) through (3) c).

(6) The Benefits of a plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:

a) First, the Benefits of a plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);

b) Second, the Benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(8) If none of the above rules determine the order of benefits, the benefits of the plan which covered you longer are determined before those of the plan which covered you for the shorter term.

(9) When determination cannot be made in accordance with the above, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

SELECTING YOUR PROVIDER

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

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

Choosing a PPO Provider
A PPO Provider potentially allows the greatest reduction in Enrollees' 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 who has not agreed to the features of the PPO plan. Payment for covered services performed by a Premier Provider is based on the Maximum Contract Allowance. The amount charged by a

Premier Provider may be above that accepted by PPO Providers but no more than the Delta Dental Premier Contracted Fee.

Choosing a Non-Delta Dental Provider
If a Provider is a Non-Delta Dental Provider, the amount charged to Enrollees may be above that accepted by PPO or Premier Providers, and Enrollees 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 the Enrollee may be balance billed up to the Provider's Submitted Fee.

Additional Obligations of PPO and Premier Providers
- The PPO Provider or Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Delta Dental after satisfaction of the Deductible and Enrollee Coinsurance. The Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Provider or Premier Provider will complete the dental Claim Form and submit it to Delta Dental for reimbursement.
- PPO and Premier Providers accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and contracted fees.

How to Submit a Claim

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

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

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

Payment Guidelines

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

If you or your Provider files a claim for services more than 12 months after the date you received the services, payment may be denied. If the services were received from a Non-Delta Dental Provider, you are still responsible for the full cost. If the payment is denied because your PPO Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your PPO Provider that you were covered under a Delta Dental Policy at the time you received the service, you may be responsible for the cost of that service.

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

Provider Relationships

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

CLAIMS AND APPEALS

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(s) for denial. For post-service claims, if you have provided all of the information needed to process the claim, we will notify you within thirty (30) days of receipt of the claim, unless an extension of up to fifteen (15) days is necessary due to matters beyond the control of the Plan. If an extension is necessary, we will notify you of the circumstances requiring the extension before the end of the thirty (30) day period and provide the date by which we expect to render a decision. If the extension is necessary because you have not submitted the information necessary to

decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice to provide the specified information.

For pre-service claims involving urgent care, we will notify you of the Plan's benefit determination (whether or not adverse) as soon as possible, taking into account the dental exigencies, but no more than seventy-two (72) hours after receipt of the pre-service claim, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. Notice of a decision on an urgent care pre-service claim may be provided orally within this time frame, provided that written or electronic notice is provided no less than three (3) days after the oral notification. If you fail to provide sufficient information for us to decide an urgent care pre-service claim, we will notify you of the specific information necessary to complete the claim as soon as possible, but no later than twenty-four (24) hours after receipt of the pre-service claim. We will allow additional time for you to provide the specified information. The additional time will be a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours. In such cases, we will notify you of our benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of (i) the receipt of the specified additional information, or (ii) the expiration of the period afforded you to provide the specified additional information.

For purposes of the Plan, a "claim involving urgent care" is any claim for care or treatment with respect to which the application of the time periods for making non-urgent care determinations (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of a licensed clinical professional with knowledge of the claimant's dental condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is a "claim involving urgent care" is determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a licensed clinical professional with knowledge of the claimant's dental condition determines is a "claim involving urgent care" shall be treated as a "claim involving urgent care" for purposes of the Plan's claims and appeals provisions.

If we have approved an ongoing course of treatment to be provided over a period of time or number of treatments, then the following applies:

- Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. We will notify you of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- Any request by you to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and we will notify you of the benefit determination (whether adverse or not) within twenty-four (24) hours after we receive the claim, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

The Plan does not currently require prior authorization to receive benefits, so you are not currently required to follow procedures for pre-service claims.

Notice of Claim Denial

If your claim is denied, we will notify you in writing and provide the following:

- The specific reason(s) for the denial;
- Specific references to the pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such material or information is necessary;
- An explanation of the Plan's review procedures and the time limits applicable to such procedures;
- Your right to bring a civil action after exhausting all claims and appeals processes;
- If your claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or a notice of where and how you can obtain a copy, free of charge;
- If your claim for benefits is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion; or include a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request;
- In the case of a denial concerning a claim involving urgent care, a description of the expedited review process applicable to such claims; and

- A statement that additional information regarding voluntary alternative dispute resolution options, such as mediation, may be obtained by contacting your local U.S. Department of Labor Office.

If the denial concerns a claim involving urgent care, the information described above may be provided to the claimant orally within the applicable time period described in "Timing of Claim Decision," provided that a written or electronic notification is furnished no later than three (3) days after the oral notification.

Timing of Appeal

You have at least 180 days after receiving a notice of denial to request an appeal or grievance by writing to us giving reasons why you believe the denial was wrong. You and your Provider will have the opportunity to submit written comments, documents, records, and other information relating to the claim and may ask Delta Dental to examine any additional information provided that may support the appeal or grievance. Upon request and free of charge, you will be provided reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits (other than legally or medically privileged documents), a copy of any internal rule, guideline, protocol and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying the claims.
Send your appeal or grievance to us at the address shown below:

Delta Dental of California
Customer Service Department
P.O. Box 997330
Sacramento, CA 95899-7330
Phone Number: 888-335-8227

Review of Appeal

For appeals of post-service claims, we will send you a written acknowledgment of receipt within five (5) days upon our receipt of the appeal or grievance. We will make a full and fair review and may ask for more documents during this review if needed. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered in the initial claim determination. The review will be conducted for us by an appropriate person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. The review does not afford deference to the initial adverse benefit determination.

If your appeal is based in whole or in part on a clinical judgment, including determinations with regard to whether a particular treatment, drug, or other item is an experimental, investigational, or unproven service or not medically necessary or appropriate, the appropriate named person will consult with an appropriately trained and experienced dentist, who will not be the individual who was consulted in connection with the initial claim determination that is the subject of the appeal nor the subordinate of such individual. Upon request, we will provide for the identification of any licensed clinical or vocational experts whose advice was obtained in connection with the denial of your claim, without regard to whether the advice was relied upon in making the claim determination.

In the case of a claim involving urgent care, (i) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and (ii) all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

Notice of Appeal Decision

For appeals of post-service claims, we will send the Enrollee a written decision within sixty (60) days after receipt of the Enrollee's appeal or grievance. If your appeal is denied, the notice will include the following:

- The specific reason(s) for the denial;
- Specific references to the pertinent Plan provisions on which the denial is based;
- Your entitlement to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures;
- Your right to bring a civil action after completion of all required levels of review;
- If your claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or a notice of where and how you can obtain a copy free of charge upon request;

- If your claim for benefits is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion; or include a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

For a claim involving urgent care, we will notify you of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of your request for review of an adverse benefit determination.

If the Enrollee believes they need further review of their appeal or grievance, they may contact their state regulatory agency if applicable.

GENERAL PROVISIONS

Non-Discrimination

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

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

If you need these services, contact Delta Dental's Customer Service Center at 800-471-0287.

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

Delta Dental
P.O. Box 997100
Sacramento, CA 95899
Telephone Number: 800-471-0287
Website Address: deltadentalins.com

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

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

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

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 attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us at our expense, in or near your community or residence. We will in every case hold such information and records confidential.

Notice of Claim Form

We will give you or your Provider, on request, 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 the form is not furnished by us within 15 days after requested by you or your Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. You or your Provider may download a Claim Form from our website.

Written Notice of Claim/Proof of Loss

We must be given written proof of loss within 12 months after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided 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).

All written proof of loss must be given to us within 12 months of the termination of the Contract.

Time of Payment

Claims payable under the Contract for any loss other than loss for which the Contract provides any periodic payment will be processed no later than 30 days after written proof of loss is received. 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 dentist. Payment for services provided by a PPO or Premier Provider will be made directly to the dentist. Any other payments provided by the Contract will be made to you. All Benefits not paid to a PPO or Premier Provider will be payable to you (the Primary Enrollee or Dependent Enrollee), or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release Benefits may be payable to an individual legally supporting the person.

Aside the foregoing, neither you, the Primary Enrollee, nor a Dependent Enrollee, nor your dependents, nor any beneficiaries may assign, sell, transfer, pledge, charge, encumber, or allow any Benefits under this group dental program without the written consent of Delta Dental. Any assignment by you will be void. To the extent allowed by law, Delta Dental will not accept an assignment to a Non-Delta Dental Provider or facility for any reason, including but not limited to, an assignment of the right to receive payments. Any payments made by Delta Dental to a Non-Delta Dental Provider or facility does not create a waiver of this section nor grant a Non-Delta Dental Provider rights under the Contract.

Misstatements on Application: Effect

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

Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued the contract at the same coverage rate. If any misstatement would materially affect the rates, we reserve the right to adjust the coverage rate to reflect your actual circumstances at enrollment.

Legal Actions

No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by the Contract.

Attachment A
Description of Dental Benefits, Deductibles, Maximums and Contract Benefit Levels

Deductible and maximum amounts will be determined on a Calendar Year basis per Enrollee unless otherwise stated and are subject to *Attachment B - Limitations and Exclusions*.

Description of Dental Benefits	
Dental Benefit **Benefit Category**	**Dental Benefit Description**
Exams Diagnostic and Preventive	evaluation to assess oral health
X-Rays Diagnostic and Preventive	radiographic imaging services to aid diagnosis
Prophylaxis Diagnostic and Preventive	services to remove plaque, tartar and stains from the tooth surface
Fluoride Diagnostic and Preventive	topical application of fluoride in the dental office
Space Maintainers Diagnostic and Preventive	oral appliance made to “maintain” the space created by the loss of a tooth
Sealants Basic	topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay
Minor Restorative Basic	amalgam (silver filling) and resin-based composite (tooth-colored filling) and prefabricated crowns for treatment of decay, failing restorations or fractures
Endodontics Basic	treatment of diseases and injuries of the tooth pulp
Periodontics; Surgical Basic	surgical treatment of gums and bones supporting teeth
Periodontics; Non-Surgical Basic	non-surgical treatment of gums and bones supporting teeth
Periodontal Maintenance Basic	a cleaning performed to maintain periodontal health after periodontal treatment
Denture Repair/Rebase/Reline Additional/Other	repair to partial or complete dentures, including rebase procedures and relining
Extractions Basic	removal of teeth
Surgical Extractions Basic	removal of teeth by opening the gums and removing bone
Other Oral Surgery Basic	oral surgery services with the exception of surgical and non-surgical extractions
Palliative Treatment Diagnostic and Preventive	treatment to relieve pain
IV Sedation & General Anesthesia Basic	when administered by a Dentist for Oral Surgery or selected endodontic and periodontal surgical procedures

Consultation	opinion or advice requested by a Dentist
Diagnostic and Preventive	
Major Restorative	treatment of decay and fracture when teeth cannot be restored with amalgam (silver filling) or resin-based composites (tooth-colored filling)
Major	
Prosthodontics; Removable	procedures for construction, modification and repair of partial or complete dentures
Additional/Other	
Prosthodontics; Fixed	procedures for construction, modification and repair of fixed bridges
Additional/Other	
Orthodontic	procedures using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function
Orthodontic	
Cone Beam CT	x-ray technique that captures multiple images of the head and neck from a variety of angles
Diagnostic and Preventive	
Professional Visits	visit for observation or after regularly scheduled hours
Basic	
Resin-based Composites - Posterior	resin-based composite (tooth-colored fillings) in the rear of the mouth for treatment of decay, failing restorations or fractures
Basic	
Dental Accident	an injury to the mouth or structures within the oral cavity which is caused by an external traumatic force. It does not include damage to the teeth which is the result of biting into food or other substances. Procedures will include, but are not limited to, reimplantation, splinting, and stayplate
Dental Accident	

Maximums

If You obtain Benefits from any combination of PPO, Premier or Non-Delta Dental Dentists during a Calendar Year, the amount We will pay each year for all Benefits received from all Dentists will not exceed the maximum amount payable for PPO Dentists. You enjoy the greatest Benefits - including out-of-pocket savings—when You choose a PPO Dentist.

	PPO Dentists	**Premier and Non-Delta Dental Dentists**
Annual Maximum	$1,625	$1,125
Lifetime Orthodontic Maximum	$750 per Enrollee per lifetime	
Dental Accident Maximum This Benefit is separate from the Annual Maximum	$750 per Enrollee per Calendar Year	

Contract Benefit Levels
Our reimbursement to Dentists is based on PPO Maximum Contract Allowance for PPO Dentists, Premier Maximum Contract Allowance for Premier Dentists and Program Allowance for Non-Delta Dental Dentists. We will pay the Contract Benefit Level for the following Benefits.

Each Calendar Year, the Contract Benefit Level will increase if an Enrollee visits a Dentist at least once during the Calendar Year. If Benefits are unused, the previous Contract Benefit Level is maintained.

If an Enrollee's coverage is disrupted for one full month, the Contract Benefit Level returns to Year 1.

Dental Benefit Category	Year 1	Year 2	Year 3	Year 4 & after
Diagnostic and Preventive	52.5%	60%	67.5%	75%
Basic	52.5%	60%	67.5%	75%
Major	52.5%	60%	67.5%	75%
Dental Accident	75%	75%	75%	75%
Additional/Other	37%	37%	37%	37%
Orthodontic	52%	52%	52%	52%

Note: If you transfer or move from one Delta Dental plan to another, you will not receive a new Calendar Year Maximum because you transferred or moved. The Maximum amount for Benefits paid by Delta Dental in a Calendar Year under both plans will not exceed the Maximum allowed under your current plan.

For example: If Delta Dental paid $500 in Benefits while you were enrolled in a previous plan and the Maximum amount of your current plan is $1,000, the total amount Delta Dental will pay for your Benefits under the current plan is $500.

Attachment B
Limitations and Exclusions

Limitations

- 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 crown where a filling would restore the tooth;
  - an inlay/onlay instead of an amalgam restoration;
  - 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
  - an overdenture instead of a denture.

- Exam and cleaning limitations:
  - We will pay for oral examinations no more than two (2) times in a Calendar Year.
  - We will pay for cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth, periodontal maintenance in the presence of inflamed gums or any combination thereof) no more than three (3) times in a Calendar Year.
  - Full mouth debridement is not allowed when performed by the same Dentist/Dentist office on the same day as evaluation procedures.
  - 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 (3) years. When allowed a full mouth debridement counts toward the maintenance frequency in the year provided.
  - Note that periodontal maintenance, Procedure Codes that include periodontal maintenance and full mouth debridement are covered as a Basic Benefit and that routine cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth) are covered as a Diagnostic and Preventive Benefit.

- Image limitations:
  - We will limit the total reimbursable amount to the Dentist's Submitted Fee for a comprehensive series of radiographic images when the fees for any combination of intraoral images in a single treatment series meet or exceed the Submitted Fee for a comprehensive intraoral series.
  - If a panoramic image is taken in conjunction with a comprehensive intraoral series, We will limit reimbursement to the Dentist's Submitted Fee for the comprehensive intraoral series, and the fee for the panoramic image will be Your responsibility. Panoramic images are not considered part of a comprehensive intraoral series.
  - Benefits are limited to one (1) comprehensive intraoral series once every 60 months.
  - Bitewing images 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 disallowed within six (6) months of a full mouth series unless warranted by special circumstances.
  - Bitewing images of any type are included in the fee of a comprehensive series when taken within six (6) months of the comprehensive images.
  - Bitewing images are limited to two (2) images for Dependent Enrollee children under age 10.
  - Image capture procedures are not separately billable services.

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

- Topical application of fluoride solutions is limited no more than three times in a Calendar Year.

- Application of caries arresting medicament is limited to twice per tooth per Calendar Year.

- Space maintainer limitations:
  - Space maintainers are limited to the initial appliance and are a Benefit for Dependent Enrollee children to age 13. A distal shoe space maintainer-fixed-unilateral is limited to Dependent Enrollee children eight (8) and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
  - Recementation of space maintainer is limited to once per lifetime.
  - The removal of a fixed space maintainer is included in the fee. An exception is made if the removal is performed by a different Dentist/Dentist office.

- Pulp vitality tests are allowed once per day when definitive treatment is not performed.

- Oral/facial photographic images are covered once every 36 months and diagnostic casts are covered once per lifetime in conjunction with Orthodontic Services only when Orthodontic Services are a covered Benefit. 3D images are not a covered Benefit.

- Sealants are limited as follows:
  - for Dependent Enrollee children through age 13 on permanent first and second molars if the molars are without caries (decay) or restorations on the occlusal surface.
  - repair or replacement of a Sealant on any tooth within 36 months of its application is included in the fee for the original placement.

- Specialist Consultations are limited to three (3) times in a 12-month period per Dentist and count toward the oral exam frequency. Screenings or assessments reported individually when covered are limited to only one (1) in a 12-month period and included if reported with any other examination on the same date of service and Dentist office.

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

- We will not cover replacement of prefabricated crowns within three (3) months of treatment if the service is provided by the same Dentist/Dentist office. Replacement restorations within three (3) months are included in the fee for the original restoration.

- Protective restorations (sedative fillings) are allowed once per tooth within a three (3) month period when definitive treatment is not performed on the same date of service.

- Therapeutic pulpotomy is limited to once per tooth every 60 months for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.

- Pulpal therapy (resorbable filling) is limited to once per tooth every 60 months. Retreatment of root canal therapy by the same Dentist/Dentist office within 24 months is considered part of the original procedure.

- 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 two (2) initial visits, two (2) interim visits and two (2) final visits to age 19.

- Retreatment of apical surgery by the same Dentist/Dentist office within 24 months is considered part of the original procedure.

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

- Periodontal limitations:
  - Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period for Enrollees age 15 and older. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be covered on the same date of service.
  - Periodontal surgery in the same quadrant is limited to once in every 24-month period and includes any surgical re-entry or scaling and root planing performed within 24-months by the same Dentist/Dentist office.
  - 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. Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
  - Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
  - 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 Dentist office.
  - 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 Service and are limited to once in a 24-month period.

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

- The following Oral Surgery procedure is limited for Dependent Enrollees to age 19 (or Orthodontic limiting age): transseptal fiberotomy/supra crestal fiberotomy, by report.

- The following Oral Surgery procedures are limited for Dependent Enrollees to age 19 (or Orthodontic limiting age) provided Orthodontic Services are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.

- 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).

- Crowns are covered not more often than once in any 60-month period except when We determine the existing crown is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

- Inlays/onlays are limited for Dependent Enrollee children to age 12 and older and are covered not more often than once in any 60-month period except when We determine the existing 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.

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

- Post and core services are covered not more than once in any 60-month period.

- Crown repairs are covered not more than once in any six (6) month period. Crowns, inlays/onlays and fixed bridges include repairs for 24 months following installation.

- Denture Repairs are covered not more than once in any 24-month period except for fixed Denture Repairs which are covered not more than once in a six (6) month period.

- Prosthodontic appliances that were provided by Us 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 age 16 and older. Replacement of a prosthodontic appliance not provided by Us will be made if We determine it is unsatisfactory and cannot be made satisfactory.

- 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.

- Recementation of crowns, inlays/onlays or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same Dentist/Dentist 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 Dentist/Dentist office.

- We limit payment for dentures to a standard partial or complete denture. 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.
  - 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.
  - 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 once (1) per arch in a six (6) month period and relining is limited to twice (2) per arch in a 12-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 once per arch in a six (6) month period and relining is limited to twice per arch in a 12-month period.

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

- We will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but We will credit the cost of a pontic or standard complete or partial denture toward the cost of the implant associated appliance, i.e., the implant supported crown or denture. The implant appliance is not covered.

- Orthodontic limitations:
  - Benefits for Orthodontic Services will be provided in periodic payments based on Your continuing eligibility.

- Benefits are not paid to repair or replace any Orthodontic appliance received.
- Benefits are not paid for Orthodontic retreatment procedures.
- Orthodontic treatment must be provided by a licensed Dentist.
- The removal of fixed Orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.

- All Orthodontic services, including direct to consumer Orthodontics, must be provided by a licensed Dentist authorized to deliver care in Your state. Claims for Benefits that are not provided by a Dentist are not eligible for reimbursement.

- The fees for synchronous/asynchronous teledentistry services are considered inclusive in overall patient management and are not a separately payable service.

- Dental Accident limitations:
  - The dental accident must occur while covered under this Plan.
  - Services and procedures must be provided within 180 days following the dental accident and while covered under this Plan.

Exclusions
We do not pay Benefits for:

- 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.

- Cosmetic surgery or procedures for purely cosmetic reasons.

- Maxillofacial prosthetics.

- Provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for Dependent Enrollee 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.

- 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 Dependent Enrollee children for medically diagnosed congenital defects or birth abnormalities.

- 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.

- Any Single Procedure provided prior to the date the Enrollee became eligible for Benefits under this Plan.

- Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

- Charges for anesthesia, other than General Anesthesia and IV Sedation in connection with Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.

- Extra oral grafts (grafts of tissues obtained from extraoral sites of the Enrollee's own body to their oral tissues).

- Fixed bridges and removable partials for Dependent Enrollee children under age 16.

- Interim implants, endodontic endosseous implant and extraoral implants.

- Indirectly fabricated resin-based inlays/onlays.

- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

- Treatment by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.

- Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, image duplications, cancer screening or tobacco counseling.

- 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.

- Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.
- Deductibles, amounts over plan maximums and/or any service not covered under this Plan.
- Services covered but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- Services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Benefits section.
- Services for any disturbance of TMJ or associated musculature, nerves and other tissues except as provided under the TMJ Benefit section.
- Missed and/or cancelled appointments.
- Actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- The fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- Dental case management motivational interviewing and patient education to improve oral health literacy.
- Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- Extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.
- Diabetes testing.
- Corticotomy (specialized Oral Surgery procedure associated with Orthodontics).
- Antigen or antibody testing.
- Counseling for the control and prevention of adverse oral, behavioral and systemic health effects associated with high-risk substance use.
- Services or supplies for sleep apnea.
- Cone beam image capture only is not a covered Benefit.

Attachment C
Smileway Benefits

Wellness Benefits are available to help improve the oral health of Enrollees with certain Qualifying Medical Conditions.

Qualifying Medical Conditions
Enrollees with one or more of the following Qualifying Medical Conditions will receive Wellness Benefits: cardiovascular (heart) disease; diabetes; cerebrovascular disease (stroke); HIV/AIDS; rheumatoid arthritis; chronic kidney disease; Sjogren's syndrome; lupus; Parkinson's disease; amyotrophic lateral sclerosis; Huntington's disease; opioid misuse and addiction; joint replacement; and cancer.

Wellness Benefits
The information in the table below replaces the coverage for routine cleanings, periodontal maintenance and periodontal scaling and root planing described in Attachments A and B.

Service	PPO Providers' Contract Benefit Level	Premier and Non-Delta Dental Providers' Contract Benefit Level	Limitations
Routine Cleaning & Periodontal Maintenance	100%	100%	any combination of four (4) each Calendar Year
Periodontal Scaling & Root Planing	100%	100%	once every Calendar Year per quadrant with no more than two (2) quadrants covered on the same date of service.

All other Benefits, Limitations and Exclusions remain unchanged. Wellness Benefits are subject to applicable Deductibles and Maximums.

Signing up for Wellness Benefits

1. Go to deltadentalins.com.
2. Log in to your Online Services account. (If you don't have one, click Register.)
3. Click on the Optional Benefits tab in the left column.
4. Click on Opt In next to the name of the person you want to enroll. You can enroll yourself or a dependent child.
5. Complete and submit the form.