DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Evidence of Coverage

The Boeing Company
IAM

Provided by:

ALPHA Dental Programs, Inc.
1701 Shoal Creek
Suite 240
Highland Village, TX 75077

Administered by:

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023
800-422-4234

deltadentalins.com

Delta Dental of Washington shall determine whether services are Covered Dental Benefits in accordance with standard dental practice and the Limitations and Exclusions shown in this document. Should there be a disagreement regarding the interpretation of such benefits, the subscriber shall have the right to appeal the determination in accordance with the non-binding appeals process in this document and may seek judicial review of any denial of coverage of benefits.

The Boeing Company
IAM 837

Labor Code	Labor Group
432	International Association of Machinists and Aerospace Workers, AFL-CIO, Local 837 A - St. Louis, Missouri
433	International Association of Machinists and Aerospace Workers, AFL-CIO, Local 837 B - St. Louis, Missouri
435	International Association of Machinists and Aerospace Workers, AFL-CIO, Local 837 D - St. Louis, Missouri

To confirm coverage of one of the eligible populations listed, please contact the Plan Administrator or The Boeing Service Center.

For questions or information regarding your coverage please contact Delta Dental of California's Customer Service department at 800-422-4234.

The Summary Plan Description for this Plan is The Boeing Company Health and Welfare Plans booklet for the eligible population, any applicable provider directory and this coverage-specific brochure issued by Delta Dental of California.

For detailed information concerning employee and dependent eligibility, enrollment, contributions, coverage terminations, leave of absence provisions, eligibility review and appeals, Qualified Medical Child Support Order (QMCSO), ERISA Special Disclosures and other general plan information, refer to The Boeing Health and Welfare Plans Summary Plan Description, which supercedes any eligibility information contained in this document, or contact the plan administrator.

The health plan benefit description is incorporated as part of the Boeing Summary Plan Description.

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Dentegra Insurance Company ("Dentegra"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued
by Dentegra.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

ANY MEMBER IN A PREPAID DENTAL PLAN IS FREE TO SELECT ANY LICENSED DENTAL PRACTITIONER TO PROVIDE DENTAL SERVICES. HOWEVER, BENEFITS DIFFER DEPENDING ON WHETHER TREATMENT IS RECEIVED FROM A NETWORK DENTIST OR A NON-NETWORK DENTIST. Please refer to *Benefits, Limitations and Exclusions* and *Schedule A, Description of Benefits and Copayments,* for a complete description of Benefits.

ENROLLEES WHO SEEK TREATMENT FROM NON-NETWORK DENTISTS ARE RESPONSIBLE FOR THE DIFFERENCE, IF ANY, BETWEEN THE AMOUNT DENTEGRA PAYS AND THE NON-NETWORK DENTIST'S USUAL FEE FOR SUCH TREATMENT.

The telephone number where you may obtain information about Benefits is 800-422-4234.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental") or other entity designated by Alpha, operating as an Administrator in Missouri. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Alpha. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Authorization means the process by which Alpha determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

Eligible Employee means any employee or group member who is eligible for Benefits as described in this booklet.

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist

that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Alpha.

We, Us or Our means Alpha or the Administrator as appropriate.

Eligibility for Benefits

Eligible Employees and Eligible Dependents receive Benefits as soon as they are enrolled in the Program. Subject to cancellation as provided under this Program, enrollment of Eligible Employees and Eligible Dependents is for a minimum period of one year.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:
1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);
2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children beyond the limiting age if they are wholly dependent on you for support and are Full-Time Students.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Legally adopted children (other than newborns) are eligible during and after the period of probation.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

Dependents in active military service are not eligible. No Eligible Dependent may be enrolled under more than one Eligible Employee. Medicare eligibility shall not affect the eligibility of an Eligible Employee or an Eligible Dependent.

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Program - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY US, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Alpha terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by us. All authorized Specialist Services will be paid by us less any applicable Copayments.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments* and *Limitations and Exclusions of Benefits* to determine which procedures are covered under this Program.

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be submitted to Alpha within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for the provisions in *Emergency Services*, if you have not received Authorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Alpha, and Alpha may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Alpha shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Alpha shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Alpha chooses, the amount of any Benefits paid by Alpha which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Alpha or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Alpha or the Administrator, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

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

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Alpha within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole

or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Alpha shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a Dentist for a clinical evaluation of the dental services provided. We will make a determination, in writing, within 30 days of receipt of a complaint or shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall be undertaken if a written request for an appeal of the determination is made within 30 days of the date of the written determination. We shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary, in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

The Missouri Department of Insurance is responsible for regulating Prepaid Dental Plans. If you have a grievance against your health plan, you should first telephone your health plan at 800-422-4234 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. The Department of insurance may be reached at:

State of Missouri Department of Insurance
P.O. Box 690
Jefferson City, Missouri 65102-0690
573-751-4362
800-726-7390

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Certificate of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;

2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;

3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
   c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Alpha must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Alpha will notify the Enrollee in writing, at least 30 days in advance, that Alpha considers the dentist-patient relationships to be unsatisfactory. Alpha will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

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

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Alpha plan on the day before the Qualifying Event, or

2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1. the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;

Event 2. your death;

Event 3. your divorce or legal separation from your spouse;

Event 4. your dependent's loss of dependent status under the plan; and

Event 5. as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:
1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Alpha within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Alpha within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Alpha terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Alpha plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Alpha plan.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as CDT-2018 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

Code	Description	Enrollee Copay
D0100-D0999	**I. DIAGNOSTIC**	
	- *Radiographic images (x-ray) copayment applies to the assigned general dentist only. If additional radiographic images are required from a specialist, additional fees may apply.*	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	$5.00
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0330	Panoramic radiographic image	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D1000-D1999	**II. PREVENTIVE**	
D1110	Prophylaxis *cleaning* - adult - *2 per 12 month period*	No Cost
D1120	Prophylaxis *cleaning* - child - *2 per 12 month period*	No Cost
D1206	Topical application of fluoride varnish - *child to age 19; 2 D1206 or D1208 per 12 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 2 D1206 or D1208 per 12 month period*	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	No Cost
D1510	Space maintainer - fixed - unilateral	No Cost
D1515	Space maintainer - fixed - bilateral	No Cost
D1520	Space maintainer - removable - unilateral	No Cost
D1525	Space maintainer - removable - bilateral	No Cost
D1550	Re-cement or re-bond space maintainer	No Cost

D1575	Distal shoe space maintainer - fixed - unilateral - *child to age 9*	No Cost

D2000-D2999 III. RESTORATIVE

- *Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.*
- *Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.*
- *Copayments include additional lab fee.*

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2391	Resin-based composite - one surface, posterior	No Cost
D2392	Resin-based composite - two surfaces, posterior	No Cost
D2393	Resin-based composite - three surfaces, posterior	No Cost
D2394	Resin-based composite - four or more surfaces, posterior	No Cost
D2740	Crown - porcelain/ceramic	$295.00
D2750	Crown - porcelain fused to high noble metal	$295.00
D2751	Crown - porcelain fused to predominantly base metal	$195.00
D2752	Crown - porcelain fused to noble metal	$235.00
D2790	Crown - full cast high noble metal	$260.00
D2791	Crown - full cast predominantly base metal	$160.00
D2792	Crown - full cast noble metal	$200.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2950	Core buildup, including any pins when required	No Cost

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Cost
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	No Cost
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	No Cost
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	No Cost
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	No Cost
D3346	Retreatment of previous root canal therapy - anterior	No Cost
D3347	Retreatment of previous root canal therapy - premolar	No Cost
D3348	Retreatment of previous root canal therapy - molar	No Cost

D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	No Cost
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	No Cost
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	No Cost
D3410	Apicoectomy - anterior	No Cost
D3421	Apicoectomy - premolar (first root)	No Cost
D3425	Apicoectomy - molar (first root)	No Cost
D3426	Apicoectomy (each additional root)	No Cost
D3430	Retrograde filling - per root	No Cost
D3450	Root amputation - per root	No Cost

D4000-D4999 V. PERIODONTICS

- *ncludes preoperative and postoperative evaluations and treatment under a local anesthetic.*

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$31.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$10.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$10.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$33.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$33.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$114.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$114.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$12.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$12.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *2 per 12 month period*	No Cost
D4910	Periodontal maintenance - *limited to 2 treatments each 12 month period*	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- *For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.*
- *Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.*
- *Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.*
- *Copayments include additional lab fee.*

D5110	Complete denture - maxillary	$215.00
D5120	Complete denture - mandibular	$215.00
D5130	Immediate denture - maxillary	$235.00
D5140	Immediate denture - mandibular	$235.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$195.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$195.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$240.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$240.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$290.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$290.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$195.00
D5410	Adjust complete denture - maxillary	No Cost
D5411	Adjust complete denture - mandibular	No Cost
D5421	Adjust partial denture - maxillary	No Cost
D5422	Adjust partial denture - mandibular	No Cost
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$30.00
D5611	Repair resin partial denture base, mandibular	$65.00
D5612	Repair resin partial denture base, maxillary	$65.00
D5621	Repair cast partial framework, mandibular	$60.00
D5622	Repair cast partial framework, maxillary	$60.00
D5630	Repair or replace broken clasp - per tooth	$60.00
D5640	Replace broken teeth - per tooth	$40.00
D5650	Add tooth to existing partial denture	$40.00
D5660	Add clasp to existing partial denture - per tooth	$60.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$40.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$40.00
D5710	Rebase complete maxillary denture	$70.00
D5711	Rebase complete mandibular denture	$70.00
D5720	Rebase maxillary partial denture	$70.00
D5721	Rebase mandibular partial denture	$70.00
D5730	Reline complete maxillary denture (chairside)	$65.00
D5731	Reline complete mandibular denture (chairside)	$65.00
D5740	Reline maxillary partial denture (chairside)	$65.00
D5741	Reline mandibular partial denture (chairside)	$65.00
D5750	Reline complete maxillary denture (laboratory)	$75.00
D5751	Reline complete mandibular denture (laboratory)	$75.00
D5760	Reline maxillary partial denture (laboratory)	$75.00
D5761	Reline mandibular partial denture (laboratory)	$75.00
D5810	Interim complete denture (maxillary)	$95.00
D5811	Interim complete denture (mandibular)	$95.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$95.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$95.00

D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

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

- *Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.*
- *Copayments include additional lab fee.*

D6210	Pontic - cast high noble metal	$260.00
D6211	Pontic - cast predominantly base metal	$160.00
D6212	Pontic - cast noble metal	$200.00
D6240	Pontic - porcelain fused to high noble metal	$295.00
D6241	Pontic - porcelain fused to predominantly base metal	$195.00
D6242	Pontic - porcelain fused to noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$80.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$80.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$80.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$80.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$80.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$80.00
D6606	Retainer inlay - cast noble metal, two surfaces	$80.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$80.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$80.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$80.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$80.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$80.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$80.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$80.00
D6614	Retainer onlay - cast noble metal, two surfaces	$80.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$80.00
D6740	Retainer crown - porcelain/ceramic	$295.00
D6750	Retainer crown - porcelain fused to high noble metal	$295.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$195.00
D6752	Retainer crown - porcelain fused to noble metal	$235.00
D6780	Retainer crown - 3/4 cast high noble metal	$260.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$160.00
D6782	Retainer crown - 3/4 cast noble metal	$200.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$295.00
D6790	Retainer crown - full cast high noble metal	$260.00
D6791	Retainer crown - full cast predominantly base metal	$160.00
D6792	Retainer crown - full cast noble metal	$200.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	$60.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No Cost
D7220	Removal of impacted tooth - soft tissue	No Cost
D7230	Removal of impacted tooth - partially bony	No Cost
D7240	Removal of impacted tooth - completely bony	No Cost
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	No Cost
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7410	Excision of benign lesion up to 1.25 cm	No Cost
D7411	Excision of benign lesion greater than 1.25 cm	No Cost
D7412	Excision of benign lesion, complicated	No Cost
D7413	Excision of malignant lesion up to 1.25 cm	No Cost
D7414	Excision of malignant lesion greater than 1.25 cm	No Cost
D7415	Excision of malignant lesion, complicated	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7520	Incision and drainage of abscess - extraoral soft tissue	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost

D8000-D8999 XI. ORTHODONTICS

- *The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.*
- *The Retention Copayment includes adjustments and/or office visits up to 24 months.*

	Pre and post orthodontic records include:	
	The benefit for pre-treatment records and diagnostic services includes:	$200.00
D0210	Intraoral - complete series of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intraorally or extraorally	
D0351	3D photographic image	
D0470	Diagnostic casts	
	The benefit for post-treatment records includes:	$70.00
D0210	Intraoral - complete series of radiographic images	

D0470	Diagnostic casts	
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$2,750.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$2,750.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$2,975.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8670	Periodic orthodontic treatment visit - *included in comprehensive case fee*	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	No Cost
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	No Cost
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	No Cost
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	No Cost
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	No Cost
D9951	Occlusal adjustment, limited	No Cost
D9952	Occlusal adjustment, complete	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Alpha. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

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

2. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).

3. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Alpha, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

4. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.

5. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Alpha is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

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

2. Any procedure that in the professional opinion of the Contract Dentist:

   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**

   b. is inconsistent with generally accepted standards for dentistry.

3. Services solely for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.

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

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

6. Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).

7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.

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

9. Consultations for non-covered benefits.

10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Certificate of Coverage.

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

12. Prescription drugs.

13. Dental conditions arising out of and due to Enrollee's employment for which Workers' Compensation is payable. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision.

14. Extensive treatment plans involving six (6) or more crowns or units of fixed bridgework (major mouth reconstruction).

15. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.

16. Lost, stolen or broken orthodontic appliances.

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

18. Extractions solely for the purpose of orthodontics.

19. Myofunctional and parafunctional appliances and/or therapies.

20. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

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

Claimants have the right to bring a civil action under Section 502(a) of ERISA, after having exhausted the internal benefit determination process.

If you have any questions or need additional information, call or write:

Toll Free
800-422-4234

Administrator:
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023