DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Evidence of Coverage

The Boeing Company

Provided by:

Alpha Dental of Arizona, Inc.
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703

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
MDC Salaried

Labor Code	Labor Group
100M	Nonunion Retirees - (includes ISG, all nonunion hourly and nonunion salaried retirees, and helicopter salaried retirees)

The Boeing Company
NUS

Labor Code	Labor Group
101	Nonunion Employees
120	Nonunion Employees
124	Nonunion Employees
126	Nonunion Employees
130	Nonunion Employees
170	Nonunion Employees
325	Nonunion Employees
415	Nonunion Employees
702	Nonunion Employees
710	Nonunion Employees
711	Nonunion Employees
713	Nonunion Employees
724	Nonunion Charleston Flight Line
727	Nonunion Employees

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"), a third party entity designated to perform administrative functions described throughout the Contract, including, but not limited to, the collection of Premium and eligibility.

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.

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 Enrollee who is eligible for Benefits as described in this booklet.

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

EMERGENCY SERVICES mean dental services intended to evaluate and stabilize a dental condition of recent onset, control bleeding, and relieve pain, and includes the provision of local anesthesia, and elimination of acute infection, but does not mean a medication that is prescribed by the Dentist.

ENROLLEE means an Eligible Enrollee ("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.

GROUP means the employer or other organization contracting to obtain Benefits for Eligible Enrollees.

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 Us.

SPOUSE means a person related to You or Your partner:
- as defined and as may be required to be treated as a Spouse by the laws of the state where this Contract is issued and delivered;
- as defined and as may be required to be treated as a Spouse by the laws of the state where You reside; and
- as may be recognized by the Group.

WE, US or OUR means Alpha.

YOU or YOUR means the Primary Enrollee.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Enrollee if You meet the eligibility requirements defined by the Group.

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 Your Spouse and unmarried dependent children from birth to age 19, or to age 25 if enrolled as full-time students in an accredited school, college or university.

Children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as recognized by the Group. Children/students must be dependent upon You for support and maintenance. Your dependents are eligible to enroll on the same date that You become a Primary Enrollee. Later-acquired dependents become eligible as soon as they acquire dependent status.

An overage unmarried dependent child may be eligible if:
1) the child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that began prior to reaching the limiting age;
2) the child is chiefly dependent on 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 following a two year period after this dependent reaches the limiting age. Enrollment will continue as long as the dependent relies on the Eligible Employee for support because of a physical disability or mental incapacity.

Dependents on active military duty are not eligible. No Eligible Dependent may be enrolled under more than one Eligible Enrollee. Medicare eligibility will not affect eligibility of an Eligible Enrollee or 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 Group 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 Dependent Enrollees may select no more than three Contract Dentist facilities. If You fail to select a Contract Dentist for Yourself or Your Dependent Enrollees or the Contract Dentist selected becomes unavailable, We will request the selection of another Contract Dentist or assign a Contract Dentist. The assigned Contract Dentist may be changed by directing a request to the Customer Service department at (800) 422-4234. In order to ensure that the 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 the assigned Contract Dentist. After the effective date in Your membership packet, You and Your Dependent Enrollees may obtain dental services which are Benefits. To make an appointment, simply call the Contract Dentist's facility and identify Yourself or Your Dependent Enrollee 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.

YOU AND YOUR DEPENDENT ENROLLEES MUST GO TO THE 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 the assigned Contract Dentist's agreement with Us 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 the 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 or Your Dependent Enrollee should contact the assigned Contract Dentist for Emergency Services whenever possible. Contract Dentists maintain a 24-hour emergency services system seven days a week. If You or Your Dependent Enrollee are unable to reach the assigned Contract Dentist for Emergency Services, You or Your Dependent Enrollee should call Customer Service at (800) 422-4234 for assistance in obtaining urgent care. During non-business hours or if You or Your Dependent Enrollee are 35 miles or more from the assigned Contract Dentist, You or Your Dependent Enrollee do not need a referral and may seek treatment from a Dentist other than the 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.

Once We receive Your claim, We will reimburse You subject to the terms and conditions of Your DeltaCare USA coverage. Reimbursement is based on the out-of-network emergency benefit provided through Your Group plan, noted above. As with any dental plan, this reimbursement may not cover the entire cost of the treatment rendered.

Out-of-network emergency dental care is intended to evaluate and stabilize a dental condition of recent onset, control bleeding, relieve pain and eliminate acute infection in the event You or Your Dependent Enrollee are unable to reach the assigned Contract Dentist. 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 You or Your Dependent Enrollee require Specialist Services and there is no Contract Specialist to provide these services within 35 miles of You or Your Dependent Enrollee's home address, the assigned Contract Dentist must receive Authorization from Us to refer You or Your Dependent Enrollee to an out-of-network Dentist to provide the Specialist Services. Specialist Services performed by an out-of-network Dentist that are not authorized are not covered.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments* and *Limitations and Exclusions* 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 Us 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 or Your Dependent Enrollee 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

If You or Your Dependent Enrollee is an insured or certificate holder under an indemnity health insurance policy which provides benefits for the same treatment as a prepaid dental plan, the indemnity health insurance policy, if issued after September 15, 1989, will pay benefits to You or Your Dependent Enrollee or the assignee thereof, without regard to the existence of this prepaid dental plan.

The determination of which policy or program is primary will be governed by the rules stated in the Contract.

The indemnity plan insurer is not obligated to pay any amount for a procedure covered without charge to You or to pay in excess of the amount of Your copayment obligation under this prepaid dental plan. In the event that the Your obligation under this prepaid dental plan has been met, then the indemnity insurer will remit any payments due to You.

You must provide to Us and We may release to or obtain from any insurance company or other organization, any information about You or Your Dependent Enrollee that is needed to administer coordination of benefits. We will, in Our 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 will be deemed to be Benefits under this Contract. We will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as We choose, the amount of any Benefits paid by Us which exceeds Our obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

We will 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, Our policies, procedures or operations, 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, GA 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 Group 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 Us 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 will 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, We will 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 five 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 or Your Dependent Enrollee 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 will provide a written explanation if additional time is required to

report on the complaint. A review of the decision will be undertaken if a written request for an appeal of the determination is made within 30 days of the date of the written determination. We will undertake a full and fair review upon request. We may require additional documents, as We deem necessary in making such a review. We will 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.

We will review appeals based upon the terms and conditions of this Contract. The following levels of review will be available to You:

Expedited Dental Review
Informal Reconsideration
Formal Appeal
External Independent Review

A separate Health Care Insurer Appeals Process Information Packet, which describes the appeal process You may pursue, is included with the Evidence of Coverage at initial enrollment and subsequently upon request to Us.

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 Group does not accept the change. All Benefits terminate for You and Your Dependent Enrollees as of the date that this Program is terminated, You or Your Dependent Enrollees cease to be eligible under the terms of this Program, or Your or Your Dependent Enrollees enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to You or Your Dependent Enrollees 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, Your or Your Dependent Enrollees 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 Evidence of Coverage; or
   b) if You or Your Dependent Enrollees engage 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 You or Your Dependent Enrollees on the date due. However You and Your Dependent Enrollees may continue to receive Benefits during the 15-day period and may be reinstated during the term of this Contract upon payment of any unpaid premium; or
   b) You or Your Dependent Enrollees knowingly commit or permit another person to commit fraud or deception in obtaining Benefits under the Program;
3) Upon 30 days written notice if
   a) the Contract is terminated or not renewed;
   b) You fail to pay Copayments. However, You 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. We must show that We have, in good faith, provided You and Your Dependent Enrollees with the opportunity to select an alternative Contract Dentist. If the You or Your Dependent Enrollees establish a history of unsatisfactory relationships, We will notify You in writing, at least 30 days in advance, that We consider the dentist- patient relationships to be unsatisfactory. We will also specify the changes that are necessary in order to avoid cancellation, and show that You failed to make these changes;

Cancellation of Your enrollment will automatically cancel the enrollment of any of Your 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 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 dependents' 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 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, the Primary Enrollee may choose to continue coverage until 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 must notify Us within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify the 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 the 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 the 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 must notify Us 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 Us and the employer terminates prior to the time that the continuation coverage would otherwise terminate, the employer must 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 Our plan had such plan with the former employer not terminated. The employer must 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 Our plan.

Non-Discrimination

Alpha is committed to ensuring that no person is excluded from, or denied the benefits of our services, or otherwise discriminated against on the basis of race, color, national origin, disability, age, genetic testing, sexual orientation or gender identity. Any person who believes that he or she has individually, or as a member of any specific class of persons, been subjected to discrimination may file a complaint in writing to:

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

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 Current Dental Terminology ("CDT"), CDT-2022 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental 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, or more frequently if medically necessary*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost

D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0704	3-D photographic image - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost
D0709	Intraoral - complete series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period, or more frequently if medically necessary*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period, or more frequently if medically necessary*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *1 D1206 or D1208 per 6 month period, or more frequently if medically necessary*	No Cost
D1208	Topical application of fluoride - excluding varnish - *1 D1206 or D1208 per 6 month period, or more frequently if medically necessary*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth	$5.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	$5.00
D1353	Sealant repair - per tooth	$5.00

D1354	Application of caries arresting medicament - per tooth - *child to age 19; 1 per 6 month period, or more frequently if medically necessary*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$10.00
D1516	Space maintainer - fixed - bilateral, maxillary	$10.00
D1517	Space maintainer - fixed - bilateral, mandibular	$10.00
D1520	Space maintainer - removable - unilateral - per quadrant	$10.00
D1526	Space maintainer - removable - bilateral, maxillary .	$10.00
D1527	Space maintainer - removable - bilateral, mandibular	$10.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No Cost
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No Cost
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No Cost
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Cost
D1557	Removal of fixed bilateral space maintainer - maxillary	No Cost
D1558	Removal of fixed bilateral space maintainer - mandibular	No Cost
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	$10.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $100.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old, or more frequently if medically necessary.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent ..	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost

D2332	Resin-based composite - three surfaces, anterior ...	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior ...	$55.00
D2393	Resin-based composite - three surfaces, posterior .	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	No Cost
D2520	Inlay - metallic - two surfaces	No Cost
D2530	Inlay - metallic - three or more surfaces	No Cost
D2542	Onlay - metallic - two surfaces	No Cost
D2543	Onlay - metallic - three surfaces	No Cost
D2544	Onlay - metallic - four or more surfaces	No Cost
D2610	Inlay - porcelain/ceramic - one surface	$135.00
D2620	Inlay - porcelain/ceramic - two surfaces	$150.00
D2630	Inlay - porcelain/ceramic - three or more surfaces ..	$160.00
D2642	Onlay - porcelain/ceramic - two surfaces	$150.00
D2643	Onlay - porcelain/ceramic - three surfaces	$165.00
D2644	Onlay - porcelain/ceramic - four or more surfaces ..	$175.00
D2650	Inlay - resin-based composite - one surface	$85.00
D2651	Inlay - resin-based composite - two surfaces	$95.00
D2652	Inlay - resin-based composite - three or more surfaces	$115.00
D2662	Onlay - resin-based composite - two surfaces	$110.00
D2663	Onlay - resin-based composite - three surfaces	$120.00
D2664	Onlay - resin-based composite - four or more surfaces	$145.00
D2710	Crown - resin-based composite (indirect)	$35.00
D2712	Crown - 3/4 resin-based composite (indirect)	$35.00
D2720	Crown - resin with high noble metal	$155.00
D2721	Crown - resin with predominantly base metal	$55.00
D2722	Crown - resin with noble metal	$95.00
D2740	Crown - porcelain/ceramic	$195.00
D2750	Crown - porcelain fused to high noble metal	$195.00

D2751	Crown - porcelain fused to predominantly base metal	$95.00
D2752	Crown - porcelain fused to noble metal	$135.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$195.00
D2780	Crown - 3/4 cast high noble metal	$170.00
D2781	Crown - 3/4 cast predominantly base metal	$70.00
D2782	Crown - 3/4 cast noble metal	$110.00
D2783	Crown - 3/4 porcelain/ceramic	$195.00
D2790	Crown - full cast high noble metal	$170.00
D2791	Crown - full cast predominantly base metal	$70.00
D2792	Crown - full cast noble metal	$110.00
D2794	Crown - titanium and titanium alloys	$195.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	No Cost
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$10.00
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - *anterior primary tooth*	$15.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$10.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	No Cost
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	No Cost

D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	No Cost
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	No Cost
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework.	$19.00
D2980	Crown repair necessitated by restorative material failure	$10.00
D2981	Inlay repair necessitated by restorative material failure	$10.00
D2982	Onlay repair necessitated by restorative material failure	$10.00
D2983	Veneer repair necessitated by restorative material failure	$10.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$5.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	$5.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$5.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$5.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$45.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$90.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$205.00
D3331	Treatment of root canal obstruction; non-surgical access	$45.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$45.00
D3333	Internal root repair of perforation defects	$45.00

D3346	Retreatment of previous root canal therapy - anterior	$60.00
D3347	Retreatment of previous root canal therapy - premolar	$105.00
D3348	Retreatment of previous root canal therapy - molar	$220.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
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
D3471	Surgical repair of root resorption - anterior	No Cost
D3472	Surgical repair of root resorption - premolar	No Cost
D3473	Surgical repair of root resorption - molar	No Cost
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	No Cost
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	No Cost
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	No Cost
D3920	Hemisection (including any root removal), not including root canal therapy	No Cost
D3921	Decoronation or submergence of an erupted tooth	No Cost

D4000-D4999 V. PERIODONTICS

- Includes 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	$80.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$50.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$50.00
D4245	Apically positioned flap	$75.00
D4249	Clinical crown lengthening - hard tissue	$75.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$175.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$140.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$195.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$60.00
D4270	Pedicle soft tissue graft procedure	$195.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$45.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$195.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$195.00

D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period, or more frequently if medically necessary*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	No Cost
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	No Cost
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	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.

D5110	Complete denture - maxillary	$100.00
D5120	Complete denture - mandibular	$100.00
D5130	Immediate denture - maxillary	$120.00
D5140	Immediate denture - mandibular	$120.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$80.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$80.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$120.00

D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$120.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$80.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$80.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$120.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$120.00
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery	$170.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$170.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$80.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$80.00
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	$15.00
D5512	Repair broken complete denture base, maxillary	$15.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$5.00
D5611	Repair resin partial denture base, mandibular	$15.00
D5612	Repair resin partial denture base, maxillary	$15.00
D5621	Repair cast partial framework, mandibular	$15.00
D5622	Repair cast partial framework, maxillary	$15.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$15.00
D5640	Replace broken teeth - per tooth	$5.00

D5650	Add tooth to existing partial denture	$5.00
D5660	Add clasp to existing partial denture - per tooth	$5.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$75.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$75.00
D5710	Rebase complete maxillary denture	$35.00
D5711	Rebase complete mandibular denture	$35.00
D5720	Rebase maxillary partial denture	$35.00
D5721	Rebase mandibular partial denture	$35.00
D5725	Rebase hybrid prosthesis	$35.00
D5730	Reline complete maxillary denture (chairside)	No Cost
D5731	Reline complete mandibular denture (chairside)	No Cost
D5740	Reline maxillary partial denture (chairside)	No Cost
D5741	Reline mandibular partial denture (chairside)	No Cost
D5750	Reline complete maxillary denture (laboratory)	$35.00
D5751	Reline complete mandibular denture (laboratory)	$35.00
D5760	Reline maxillary partial denture (laboratory)	$35.00
D5761	Reline mandibular partial denture (laboratory)	$35.00
D5765	Soft liner for complete or partial removable denture - indirect	$35.00
D5820	Interim partial denture (including retentive/ clasping materials, rests, and teeth), maxillary - *limited to 1 in any 12 consecutive months*	$45.00
D5821	Interim partial denture (including retentive/ clasping materials, rests, and teeth), mandibular - *limited to 1 in any 12 consecutive months*	$45.00
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])

- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$170.00
D6211	Pontic - cast predominantly base metal	$70.00
D6212	Pontic - cast noble metal	$110.00
D6240	Pontic - porcelain fused to high noble metal	$195.00
D6241	Pontic - porcelain fused to predominantly base metal	$95.00
D6242	Pontic - porcelain fused to noble metal	$135.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$135.00
D6245	Pontic - porcelain/ceramic	$195.00
D6250	Pontic - resin with high noble metal	$155.00
D6251	Pontic - resin with predominantly base metal	$55.00
D6252	Pontic - resin with noble metal	$95.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$150.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$160.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$100.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$100.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces	$40.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$40.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$150.00

D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$165.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$100.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$100.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces	$40.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$40.00
D6720	Retainer crown - resin with high noble metal	$155.00
D6721	Retainer crown - resin with predominantly base metal	$55.00
D6722	Retainer crown - resin with noble metal	$95.00
D6740	Retainer crown - porcelain/ceramic	$195.00
D6750	Retainer crown - porcelain fused to high noble metal	$195.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$95.00
D6752	Retainer crown - porcelain fused to noble metal	$135.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$195.00
D6780	Retainer crown - 3/4 cast high noble metal	$170.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$70.00
D6782	Retainer crown - 3/4 cast noble metal	$110.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$195.00
D6784	Retainer crown - titanium and titanium alloys	$170.00
D6790	Retainer crown - full cast high noble metal	$170.00
D6791	Retainer crown - full cast predominantly base metal	$70.00
D6792	Retainer crown - full cast noble metal	$110.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	$10.00

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	$15.00
D7220	Removal of impacted tooth - soft tissue	$25.00
D7230	Removal of impacted tooth - partially bony	$50.00
D7240	Removal of impacted tooth - completely bony	$70.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$90.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	$90.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$50.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted 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
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost

D7473	Removal of torus mandibularis	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost
D7970	Excision of hyperplastic tissue - per arch	$50.00
D7971	Excision of pericoronal gingiva	$50.00

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	

D8010	Limited orthodontic treatment of the primary dentition	$950.00
D8020	Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$950.00

D8030	Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$950.00
D8040	Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$1,700.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,700.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,900.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
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	$5.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	$80.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$80.00
D9239	Intravenous moderate (conscious) sedation/ analgesia - first 15 minutes	$80.00
D9243	Intravenous moderate (conscious) sedation/ analgesia - each subsequent 15 minute increment	$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost

D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	$0.00
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$20.00
D9952	Occlusal adjustment, complete	$40.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *includes failed appointment without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *includes failed appointment without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost

D9996 Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review .... No Cost

D9997 Dental case management - Patients with special Health Care Needs ..... No Cost

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. Questions regarding the DeltaCare USA Program should be directed to the Customer Service department at 800-422 4234.

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. If the Enrollee accepts a treatment plan from the general Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. 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).
4. 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 Us, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. 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.
6. 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. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

7. Benefits for a soft tissue management program are limited to those parts which are listed covered services listed on *Schedule A, Description of Benefits and Copayments.*

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, with the exception of procedure D9975 (External bleaching for home application, per arch), 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) when the affected teeth have not reached completion of dental and skeletal growth.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. 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 Evidence 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 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.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures D9944, D9945, D9946 (occlusal guard).
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Any part of a preventive or soft tissue management program which is not a listed covered service on *Schedule A, Description of Benefits and Copayments*.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.
21. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

DeltaCare USA
PO Box 1803 Alpharetta, GA 30023-1803
1-800-422-4234
deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint

Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

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

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

- qualified interpreters
- information written in other languages

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

Protect your oral health. Prevention is the key to avoiding tooth and gum problems. Brush and floss regularly, and visit the dentist for cleanings and exams. To learn more about prevention and avoiding dental problems, visit **deltadentalins.com**. You'll find oral health articles, videos and other tools and tips for caring for your teeth. Don't forget to sign up for *Grin!*, our free dental health e-magazine.

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

Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call 1-800-422-4234 (TTY: 711).

¿Puede leer este documento? Si no, podemos encontrar a alguien que lo ayude a leerlo. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 1-800-422-4234 (servicio de retransmisión TTY deben llamar al 711). (Spanish)

您能自行閱讀本文件嗎？如果不能，我們可請人幫助您閱讀。您還可以請人以您的語言撰寫本文件。如需免費幫助，請致電 1-800-422-4234 (TTY: 711)。(Chinese)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 1-800-422-4234 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-800-422-4234 (TTY: 711)번으로 연락하십시오. (Korean)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-800-422-4234 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-800-422-4234 (телетайп: 711). (Russian)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نوفر لك من يساعدك في قراءتها. ربما يمكنك أيضًا الحصول على هذا المستند مكتوبًا بلغتك للمساعدة المجانية اتصل بـ 1-800-422-4234 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-800-422-4234 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n'est pas le cas, nous pouvons faire en sorte que quelqu'un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l'assistance gratuitement, veuillez appeler le 1-800-422-4234 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-800-422-4234 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-800-422-4234 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-800-422-4234 (TTY: 711). (Italian)

この文書をお読みになれますか?お読みになれない場合には音読ボランティアを手配させていただきます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、1-800-422-4234 (TTY: 711) までお問い合わせください。(Japanese)

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 1-800-422-4234 (Schreibtelefon: 711). (German)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخواهیم تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 1-800-422-4234 (TTY: 711). (Persian Farsi)

क्या आप इस दस्तावेज़ को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी सहायता करने हेतु किसी की व्यवस्था कर सकते हैं। आप इस दस्तावेज़ को अपनी भाषा में लिखा हुआ भी प्राप्त कर सकते हैं। निशुल्क सहायता के लिए, कृपया यहाँ कॉल करें 1-800-422-4234 (TTY: 711)। (Hindi)

คุณสามารถอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย รับความชวยเหลือฟรีได้โดยโทรไปที่ 1-800-422-4234 (TTY: 711) (Thai)

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ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-800-422-4234 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 1-800-422-4234 (TTY՝ 711): (Armenian)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-800-422-4234 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-800-422-4234 (TTY: 711)។ (Cambodian)

צי קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט,עמעצער דאָ קען איר העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אַז איר קענט באַקומען דעם דאָזיקן דאָקומענט אין אַנדער שפּראַך. פֿאַר אומזיסטע הילף קענט איר אַנקלינגען אַט די דאָזיקע נומער: 1-800-422-4234 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'į' yídóołtahígíí nihee hóló. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaagoałdó' nich'į' ádoolnį́łgo bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojį' béésh holdíílnih 1-800-422-4234 (TTY: 711) (Navajo)

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