DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Combined Evidence of Coverage and Disclosure Form

The Boeing Company
BNA

Provided by:

Delta Dental of California
18000 Studebaker Road, Suite 530
Cerritos, CA 90703
800-422-4234

Administered by:

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

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
BNA – Hourly
(Pre 2004 Retirees)

Labor Code	Labor Group
501P	International Union, United Automobile, Aerospace and Agriculture Implement Workers of America, Local 887 - El Toro and Palmdale, California
505P	International Union, United Automobile, Aerospace and Agriculture Implement Workers of America, Local 1519 - All locations
513P	International Union, United Automobile, Aerospace and Agriculture Implement Workers of America, Local 952 - Tulsa, Oklahoma (COBRA only)
514P	International Union, United Automobile, Aerospace and Agriculture Implement Workers of America, Local 1558 - McAlester, Oklahoma (COBRA only)
561P	International Brotherhood of Carpenters & Joiners of America, Local 721 - LA Basin, California (Carpenters)
562P	International Brotherhood of Electrical Workers, AFL-CIO, Local 2295 - LA Basin, California
565P	International Brotherhood of Painters & Allied Trades of America, Local 36 - California (Painters)
567P	Sheet Metal Workers International Association, Local 461 - LA Basin, California (Welders)
568P	International Brotherhood of Teamsters, Local 952 - California (Truck Drivers)
569P	International Brotherhood of Teamsters, Local 986 - Southern California

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
DISCLOSURE FORM

Introduction

DeltaCare® USA Dental Health Care Plan

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

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

This Combined EOC and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

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

PERSONS WITH SPECIAL HEALTHCARE NEEDS SHOULD READ THE SECTION ENTITLED "SPECIAL NEEDS".

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

Request Confidential Communications

You may request to receive communications about Your protected health information from Us at an alternate address or by an alternate method. If You would like to submit a new request for confidential communications or revise or cancel an existing one, contact Us via: email: departmentriskethicsandcompliance@delta.org, or mail:

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

or visit Our website deltadentalins.com. Your request will be valid until You cancel the request or submit a new request.

Identification Card (ID)

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

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

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

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

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

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

Table Of Contents

Definitions

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

Administrator means Delta Dental Insurance Company, a third party entity designated to perform administrative functions described throughout the Contract, including, but not limited to, the collection of Premium and eligibility.

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

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 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: 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 defined in the client's SPD.

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

Emergency Service means care provided by a Dentist to treat a dental condition which manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the Enrollee to result in either: (i)

placing the Enrollee's dental health in serious jeopardy, or (ii) serious impairment to dental functions.

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

Open Enrollment Period occurs annually as established by the client.

Out-of-Network means treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits under this Program.

Preauthorization means the process by which Delta Dental determines if a procedure or treatment is a referable covered Benefit under the Enrollee's plan.

Reasonable means that an Enrollee exercises prudent judgment in determining that a dental emergency exists and makes at least one attempt to contact his/her Contract Dentist to obtain Emergency Services and, in the event the Dentist is not available, makes at least one attempt to contact Delta Dental for assistance before seeking care from another Dentist.

Service Area means the state of California.

SPD means the Boeing Health and Welfare Plan Summary Plan Description booklet.

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

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 preauthorized in writing by Delta Dental.

Treatment In Progress means any single dental procedure, as defined by the CDT Code, that has been started while the Enrollee was eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not the

Enrollee continues to be eligible for Benefits under the DeltaCare USA plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established full or partial dentures for which an impression has been taken and orthodontics when bands have been placed and tooth movement has begun.

We, Us or Our means Delta Dental of California 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

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 the period specified in the client's SPD. Legally adopted children (other than newborns) are eligible from and after the moment the child is placed in the physical custody of the Eligible Employee for adoption.

The client will determine if a dependent is eligible for coverage under a Qualified Medical Child Support Order and the effective date of coverage.

An unmarried dependent child may continue eligibility if:

1) he or she is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 60 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a physically or mentally disabling injury, illness or condition that began before he or she reached the limiting age.

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

Uniformed Services Employment and Re-employment Rights Act (USERRA) of 1994

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

Prepayment Fees/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 Plan - 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 PREAUTHORIZED IN WRITING BY DELTA DENTAL, OR FOR EMERGENCY SERVICES AS PROVIDED IN *EMERGENCY SERVICES*. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Delta Dental 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).

You may obtain an I.D. card or a network provider listing by visiting our website *deltadentalins.com*.

Continuity of Care

Current Members:

You may have the right to the benefit of completion of care with your terminated Dentist for certain specified dental conditions. Please call Customer Service at 800-422-4234 to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your terminated Dentist. We are not required to continue your care with that Dentist if you are not eligible under our policy or if we cannot reach agreement with your terminated Dentist on the terms regarding your care in accordance with California law.

New Members:

You may have the right to the qualified benefit of completion of care with an Out-of-Network Dentist for certain specified dental conditions. Please call the Customer Service department at 800-422-4234 to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your current Dentist. We are not required to continue your care with that Dentist if you are not eligible under our policy or if we cannot reach agreement with your Dentist on the terms regarding your care in accordance with California law. This policy does not apply to new Members of an individual subscriber contract.

Special Needs

If an Enrollee believes he or she has a Special Health Care Need, the Enrollee should contact Delta Dental's Customer Service department at 800-422-4234. Delta Dental will confirm that a Special Health Care Need exists, and what arrangements can be made to assist the Enrollee in obtaining such Benefits. Delta Dental shall not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Dentist treating persons with Special Health Care Needs.

Facility Accessibility

Many facilities provide Us with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding

facility accessibility, contact Our Customer Service department at 800-422-4234.

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

Emergency Services
If Emergency Services are needed, you should contact your Contract Dentist whenever possible. If you are a new Enrollee needing Emergency Services, but do not have an assigned Contract Dentist yet, contact Delta Dental's Customer Service department at 800-422-4234 for help in locating a Contract Dentist. Benefits for Emergency Services by an Out-of-Network Dentist are limited to necessary care to stabilize your condition and/or provide palliative relief when you:

1) have made a Reasonable attempt to contact the Contract Dentist and the Contract Dentist is unavailable or you cannot be seen within 24 hours of making contact; or
2) have made a Reasonable attempt to contact Delta Dental prior to receiving Emergency Services, or it is Reasonable for you to access Emergency Services without prior contact with Delta Dental; or
3) reasonably believe that your condition makes it dentally/medically inappropriate to travel to the Contract Dentist to receive Emergency Services.

Benefits for Emergency Services not provided by the Contract Dentist are limited to a maximum of $100.00 per emergency, per Enrollee, less the applicable Copayment. If the maximum is

exceeded, or the above conditions are not met, you are responsible for any charges for services by a provider other than your Contract Dentist.

Specialist Services
Specialist Services must be referred by the assigned Contract Dentist and preauthorized in writing by Delta Dental. All preauthorized Specialist Services will be paid by us less any applicable Copayments. If an Enrollee is assigned to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

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

Second Opinion

You may request a second opinion if You disagree with or question the diagnosis and/or treatment plan determination made by Your Contract Dentist. We may also request that You obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service department at 800-422-4234 or write to Delta Dental.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Delta Dental. Delta Dental will authorize a second opinion by an Out-of-Network provider if an appropriately qualified Contract Dentist is not available. Delta Dental will only pay for a second opinion which Delta Dental has approved or authorized. You will be sent a written notification should Delta Dental decide not to authorize a second opinion. If you disagree with this determination, you may file a grievance with the plan or with the Department of Managed Health Care. Refer to the *Enrollee Complaint Procedure* section for more information.

Claims for Reimbursement
Claims for covered Emergency Services or preauthorized Specialist Services should be submitted to Delta Dental within 180 days of the end of treatment. Valid claims received after the 180 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Provider Compensation
A Contract Dentist is compensated by Us through monthly capitation (an amount based on the number of Enrollees assigned to the Dentist), and by Enrollees through required Copayments for treatment received. A Contract Specialist is compensated by Us through an agreed-upon amount for each covered procedure, less the applicable Copayment paid by You. In no event do We pay a Contract Dentist or a specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. By statute, the DeltaCare USA provider contract contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental. Except for the provisions in *Emergency Services*, if you have not received Preauthorization 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.

You may obtain further information concerning compensation by calling Us at the toll-free telephone number shown in this booklet.

Processing Policies
The dental care guidelines for the DeltaCare USA Program explain to Contract Dentists what services are covered under the dental Contract. Contract Dentists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist that fall under the scope of Benefits of the dental Program are provided subject to any Copayments. If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a specialist. An Enrollee may contact Delta Dental's Customer Service department at

800-422-4234 for information regarding the dental care guidelines for DeltaCare USA.

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.

If this plan is secondary, it will pay the lesser of:
1) the amount that it would have paid in the absence of any other dental benefit coverage, or
2) the enrollee's total out-of-pocket cost payable under the primary dental benefit plan as long as the benefits are covered under this plan.

An Enrollee shall provide to Delta Dental and Delta Dental 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. Delta Dental 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. Delta Dental will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefit paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure
Delta Dental 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 Delta Dental, 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 6050

Artesia, CA 90702

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 may file a request for review (a complaint) with Delta Dental at least 180 days after receipt of the adverse determination. Delta Dental's 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, Delta Dental will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 5 calendar 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 regional dental consultant for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves severe pain and/or imminent and serious threat to a patient's dental health, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the complaint within three days.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care. You may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to your health.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **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. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

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. For additional information, refer to the client's SPD.

Public Policy Participation by Enrollees

Delta Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment program reports and communication from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to: Customer Service Department, P.O. Box 1803, Alpharetta, GA 30023.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless Delta Dental provides 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 any continued coverage option, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be cancelled, or renewal of enrollment refused, in the following events:

1) End of month upon loss of eligibility as described in the client's SPD; or
2) Upon 15 days written notice if:
   a) an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
   b) 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 30-day grace period and may be reinstated during the term of this Program upon payment of any unpaid premium; or
   c) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) As determined by the client.

Cancellation of a Primary Enrollee's enrollment, as described above, shall automatically cancel the enrollment of any of his or her Dependent Enrollees. Any cancellation is subject to the written notification requirements set forth in the Contract.

If you believe that enrollment has been cancelled or not renewed because of your health status or requirements for health care services, or that of your dependent(s), you may request a review by the Director of the California Department of Managed Health Care of the State of California. Please refer to the *Enrollee Complaint Procedure* section for more information.

Optional Continuation of Coverage (COBRA)

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history

that could result in a higher premium or you could be denied coverage entirely.

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) and the California Continuation Benefits Replacement Act (or Cal-COBRA, pertaining to employers with two to 19 employees), both require 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 and whether the Enrollee is covered under federal COBRA or Cal-COBRA.

See your employer for additional information.

DEFINITIONS

The meaning of key terms used in this section is shown below and apply to both federal and Cal-COBRA.

Qualified Beneficiary means:

1) Enrollees who are enrolled in the Delta Dental 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 UNDER FEDERAL COBRA

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.

Under federal COBRA law only, 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.

PERIODS OF CONTINUED COVERAGE UNDER CAL-COBRA
(groups of 2 - 19)

In the case of Cal-COBRA, Delta Dental will act as the administrator. Notification and premium payments should be made directly to Delta Dental. Notifications and payments should be delivered by first-class mail, certified mail, or other reliable means of delivery.

Individuals who are eligible for coverage under the federal COBRA law are not eligible for coverage under Cal-COBRA. The employer must notify Delta Dental in writing within 30 days of the date when the employer becomes subject to COBRA.

Qualified Beneficiaries may continue coverage for 36 months following the month in which Qualifying Events 1, 2, 3, 4, or 5 occur.

If, during the 36-month continuation period resulting from Qualifying Event 1, the Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to be disabled on the date of the Qualifying Event or became disabled at any time during the first 60 days of continuation coverage; and notice of the determination is given to the employer during the initial period of continuation coverage and within 60 days of the date of the social security determination letter, the Qualified Beneficiary may continue coverage for a total of 36 months following the month in which Qualifying Event 1 occurs.

This period of coverage will end on the first of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. The Qualified Beneficiary must notify the employer, or administrator within 30 days of any such determination.

If, during the 36-month continuation period resulting from Qualifying Event 1, the Qualified Beneficiary experiences Qualifying Events 2, 3, 4, or 5, he or she must notify the employer within 60 days of the second qualifying event and has a total of 36 months continuation coverage after the date of the date of the first Qualifying Event.

Delta Dental shall notify the Primary Enrollee of the date his or her continued coverage will terminate. This termination notification will be sent during the 180-day period prior to the end of coverage.

ELECTION OF CONTINUED COVERAGE

A Qualified Beneficiary will have 60 days from a Qualifying Event to give Delta Dental written notice of the election to continue coverage.

Upon written notice, Delta Dental will provide a Qualified Beneficiary with the necessary Benefits information, monthly premium charge, enrollment forms and instructions to allow election of continued coverage.

Failure to provide this written notice of election to Delta Dental within 60 days will result in the 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 Delta Dental, 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 the loss of the right to continue coverage and any premiums 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.

Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental 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 Delta Dental 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 Delta Dental plan.

Organ and Tissue Donation

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

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 and governing administrative policies of the program. Please refer to *Schedules B and C* 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 Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2024 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
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - comprehensive series of radiographic images - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost

D0240	Intraoral - occlusal radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0330	Panoramic radiographic image	No Cost
D0396	3D printing of a 3D dental surface scan	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 12 months*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 12 months*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 12 months*	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *4 per 12 month period*	No Cost
D1120	Prophylaxis *cleaning* - child - *4 per 12 month period*	No Cost

D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars to age 14*	$5.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars to age 14*	$5.00
D1353	Sealant repair - per tooth - *limited to permanent molars to age 14*	$5.00
D1354	Application of caries arresting medicament - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$15.00
D1516	Space maintainer - fixed - bilateral, maxillary	$15.00
D1517	Space maintainer - fixed - bilateral, mandibular	$15.00
D1520	Space maintainer - removable - unilateral - per quadrant	$15.00
D1526	Space maintainer - removable - bilateral, maxillary	$15.00
D1527	Space maintainer - removable - bilateral, mandibular	$15.00
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 - *child to age 9*	$15.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

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 (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2510	Inlay - metallic - one surface [3]	No Cost
D2520	Inlay - metallic - two surfaces [3]	No Cost
D2530	Inlay - metallic - three or more surfaces [3]	No Cost
D2543	Onlay - metallic - three surfaces [3]	No Cost
D2544	Onlay - metallic - four or more surfaces [3]	No Cost
D2710	Crown - resin-based composite (indirect)	$40.00
D2712	Crown - 3/4 resin-based composite (indirect)	$40.00
D2740	Crown - porcelain/ceramic [4]	$60.00
D2750	Crown - porcelain fused to high noble metal [3, 4]	$60.00
D2751	Crown - porcelain fused to predominantly base metal [4]	$60.00
D2752	Crown - porcelain fused to noble metal [4]	$60.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$60.00
D2780	Crown - 3/4 cast high noble metal [3]	$60.00
D2781	Crown - 3/4 cast predominantly base metal	$60.00
D2782	Crown - 3/4 cast noble metal	$60.00
D2790	Crown - full cast high noble metal [3]	$60.00
D2791	Crown - full cast predominantly base metal	$60.00
D2792	Crown - full cast noble metal	$60.00
D2794	Crown - titanium and titanium alloys [3]	$60.00
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
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$10.00
D2950	Core buildup, including any pins when required	$10.00
D2951	Pin retention - per tooth, in addition to restoration	$10.00
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation* [3]	$10.00
D2953	Each additional indirectly fabricated post - same tooth [3]	$10.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$10.00
D2957	Each additional prefabricated post - same tooth	$10.00
D2976	Band stabilization - per tooth - *limited to once in a lifetime per tooth*	No Cost
D2989	Excavation of a tooth resulting in the determination of non-restorability	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars to age 14*	$5.00
D2991	Application of hydroxyapatite regeneration medicament - *limited to twice per tooth in a 12 month period*	$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
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost

D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$30.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$60.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$90.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$50.00
D3346	Retreatment of previous root canal therapy - anterior	$30.00
D3347	Retreatment of previous root canal therapy - premolar	$60.00
D3348	Retreatment of previous root canal therapy - molar	$90.00
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	$50.00
D3421	Apicoectomy - premolar (first root)	$50.00
D3425	Apicoectomy - molar (first root)	$50.00
D3426	Apicoectomy (each additional root)	$50.00
D3430	Retrograde filling - per root	$50.00
D3450	Root amputation, per root - *not covered in conjunction with a hemisection*	No Cost
D3471	Surgical repair of root resorption - anterior	$50.00
D3472	Surgical repair of root resorption - premolar	$50.00
D3473	Surgical repair of root resorption - molar	$50.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$50.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$50.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$50.00

D4000-D4999 V. PERIODONTICS

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$75.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$15.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$75.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$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	$150.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$150.00
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 - *4 per 12 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	No Cost
D4910	Periodontal maintenance - *limited to 4 treatments each 12 month period*	No Cost
D4921	Gingival irrigation with a medicinal agent - per quadrant	No Cost

D5000-D5899	VI. PROSTHODONTICS (removable)	
D5110	Complete denture - maxillary	$75.00
D5120	Complete denture - mandibular	$75.00
D5130	Immediate denture - maxillary	$90.00
D5140	Immediate denture - mandibular	$90.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$85.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$85.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$85.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$85.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$85.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$85.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$85.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$85.00
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
D5710	Rebase complete maxillary denture	$30.00
D5711	Rebase complete mandibular denture	$30.00
D5720	Rebase maxillary partial denture	$30.00
D5721	Rebase mandibular partial denture	$30.00
D5725	Rebase hybrid prosthesis	$30.00
D5730	Reline complete maxillary denture (chairside)	$15.00
D5731	Reline complete mandibular denture (chairside)	$15.00
D5740	Reline maxillary partial denture (chairside)	$15.00
D5741	Reline mandibular partial denture (chairside)	$15.00
D5750	Reline complete maxillary denture (laboratory)	$30.00
D5751	Reline complete mandibular denture (laboratory)	$30.00
D5760	Reline maxillary partial denture (laboratory)	$30.00
D5761	Reline mandibular partial denture (laboratory)	$30.00
D5765	Soft liner for complete or partial removable denture - indirect	$30.00
D5820	Interim partial denture (including retentive/ clasping materials, rests, and teeth), maxillary - *limited to initial placement of interim partial denture/stayplate to replace extracted anterior teeth during healing*	No Cost
D5821	Interim partial denture (including retentive/ clasping materials, rests, and teeth), mandibular - *limited to initial placement of interim partial denture/stayplate to replace extracted anterior teeth during healing*	No Cost
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])

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

D6210	Pontic - cast high noble metal [3]	$60.00
D6211	Pontic - cast predominantly base metal	$60.00
D6212	Pontic - cast noble metal	$60.00
D6240	Pontic - porcelain fused to high noble metal [3, 4]	$60.00
D6241	Pontic - porcelain fused to predominantly base metal [4]	$60.00
D6242	Pontic - porcelain fused to noble metal [4]	$60.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$60.00
D6602	Retainer inlay - cast high noble metal, two surfaces [3]	No Cost
D6603	Retainer inlay - cast high noble metal, three or more surfaces [3]	No Cost
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	No Cost
D6607	Retainer inlay - cast noble metal, three or more surfaces	No Cost
D6611	Retainer onlay - cast high noble metal, three or more surfaces [3]	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	No Cost
D6615	Retainer onlay - cast noble metal, three or more surfaces	No Cost
D6750	Retainer crown - porcelain fused to high noble metal [3, 4]	$60.00
D6751	Retainer crown - porcelain fused to predominantly base metal [4]	$60.00
D6752	Retainer crown - porcelain fused to noble metal [4]	$60.00

D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$60.00
D6780	Retainer crown - 3/4 cast high noble metal [3]	$60.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$60.00
D6782	Retainer crown - 3/4 cast noble metal	$60.00
D6784	Retainer crown - 3/4 titanium and titanium alloys	$60.00
D6790	Retainer crown - full cast high noble metal [3]	$60.00
D6791	Retainer crown - full cast predominantly base metal	$60.00
D6792	Retainer crown - full cast noble metal	$60.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker	No Cost

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - primary tooth	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	$30.00
D7240	Removal of impacted tooth - completely bony	$40.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$40.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	$40.00
D7284	Excisional biopsy of minor salivary glands - *does not include pathology laboratory procedures*	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	$30.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$30.00

D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	$40.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	$40.00
D7471	Removal of lateral exostosis (maxilla or mandible) .	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

D8000-D8999 XI. ORTHODONTICS

D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* [1]	$1,600.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* [1]	$1,600.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children* [1]	$1,800.00
D8660	Pre-orthodontic treatment examination to monitor growth and development - *not to be charged with any other consultation procedure(s)* [2]	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) [5]	No Cost
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes the START-UP FEE, which includes initial examination, diagnosis, consultation and initial banding*	$350.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative treatment of dental pain - per visit	$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
D9440	Office visit - after regularly scheduled hours	$20.00
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
D9952	Occlusal adjustment, complete	No Cost
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$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

Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees."

FOOTNOTES

1 *Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 "Start-up fee." Beyond 24 months of active treatment, an additional office visit charge at the Contract Orthodontist's "filed fee" applies.*

2 *In the event comprehensive orthodontic treatment is not required or is declined by the Enrollee, a fee of $25.00 will apply. The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.*

3 *Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the Enrollee at the additional laboratory cost of the high noble metal. This applies to crowns (including titanium crowns), bridges, indirectly fabricated posts and cores, inlays and onlays.*

4 *Porcelain on molars is considered optional treatment.*

5 *Includes adjustments and/or office visits up to 24 months. After 24 months, an additional office visit charge at the Contract Orthodontist's "filed fee" applies.*

SCHEDULE B

Limitations and Exclusions of Benefits

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

1. Prophylaxis is limited to four treatments in a 12 month period (includes periodontal maintenance). The third and fourth treatments are a Benefit only if deemed necessary by the Contract Dentist due to Your history of periodontal disease.
2. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five-year period from initial placement.
3. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
4. Crowns and fixed partial dentures (bridges) are not to be replaced within any five year period from initial placement.
5. Denture relines are limited to one per denture during any 12 consecutive months.
6. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
7. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period.
8. Bitewing x-rays are limited to not more than one series of four films in any six month period.
9. Full mouth x-rays are limited to one set every 24 consecutive months.
10. Sealant benefits include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars up to age nine and second molars up to age 14. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.

11. 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).

Exclusions of Benefits

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

1. Cosmetic dental care.
2. Dental conditions arising out of and due to Your employment for which Workers' Compensation is paid. Services which are provided to You by state government or agency thereof, or are provided without cost to You by any municipality, county or other subdivision, except as provided in Section 1373(a) of the California Health and Safety Code.
3. Dental services performed in a hospital and related hospital fees.
4. Treatment of fractures and dislocations.
5. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures).
6. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
7. Any service that is not specifically listed as a covered expense.
8. Dental expenses incurred in connection with any dental procedure started before Your eligibility with the DeltaCare USA Plan. Examples include: teeth prepared for crowns, root canals in progress.
9. Congenital malformations (e.g. congenitally missing teeth, supernumerary).
10. Cysts and malignancies.
11. Dispensing of drugs not normally supplied in a dental facility.
12. Accidental injury. Accidental injury is defined as damage to the hard and soft tissue of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.
13. Cases in which, in the professional judgment of the Contract Dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
14. Dental services received from any Dentist facility other than the Dentist facility, unless expressly authorized in writing by Us or as outlined under Emergency Services.

15. Prophylactic removal of impactions (asymptomatic, nonpathological).
16. "Specialist consultations" for noncovered benefits.
17. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
18. Crown lengthening procedures.

Orthodontic Limitations

This Plan provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The cost to You for the treatment plan is listed in *Schedule A, Description of Benefits and Copayments* subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist.
2. Plan benefits cover 24 months of usual and customary orthodontic treatment.
3. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not Delta Dental will be responsible for payment of balance due for treatment provided after cancellation or termination. In such a case the Enrollee's payment shall be based on a maximum of $2,300 for dependent children to age 19 and $2,500 for adults, including dependent adult children. The amount will be pro-rated over the number of months to completion of the treatment and, will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the Contract Orthodontist. Start-up fees are included in these amounts.
4. Start-up fees cover the initial examination, diagnosis, consultation and the retention phase of treatment of up to two years maximum. This includes initial construction, placement and adjustments to retainers and office visits for a maximum period of two years.
5. If treatment is not required or You choose not to start treatment after the diagnosis and consultation have been completed by the Contract Orthodontist, You will be charged a consultation fee of $25.00 in addition to diagnostic record fees.
6. Three (3) recementations or replacements of a bracket/band on the same tooth or a total of five (5) rebracketings/rebandings on different teeth during the covered course of treatment is a benefit. If any additional recementations or replacements of brackets/bands are performed, You are responsible for the cost.

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

Orthodontic Exclusions

1. Pre-, mid- and post-treatment records which include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances.
3. Retreatment of orthodontic cases.
4. Changes in treatment necessitated by accident of any kind, and/or lack of patient cooperation.
5. Surgical procedures incidental to orthodontic treatment.
6. Myofunctional therapy.
7. Surgical procedures related to cleft palate, micrognathia or macrognathia.
8. Treatment related to temporomandibular joint disturbances and/or hormonal imbalance.
9. Supplemental appliances not routinely utilized in typical Phase II orthodontics.
10. Treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge at the Contract Orthodontist's "submitted fee."
11. Restorative work caused by orthodontic treatment.
12. Phase I orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.
13. Extractions solely for the purpose of orthodontics.
14. Transfer after banding has been initiated.
15. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.

SCHEDULE C

Governing Administrative Policies

Unlike medical care where the diagnosis dictates more specifically the method of treatment to be rendered, in dental care, the dentist and patient frequently consider various treatment plans.

The following guidelines are an integral part of the dental program and are consistent with the principles of accepted dental practice and the continued maintenance of good dental health.

In all cases in which the Enrollee selects a more expensive plan of treatment than is customarily provided, the more expensive treatment is considered optional. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the two plans of treatment plus any copayment for covered procedures.

Replacement of prosthetic appliances (crowns, bridges, partials and full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement.

1. PARTIAL DENTURES

   A removable cast metal partial denture is considered an adequate restoration. If the Enrollee selects another course of treatment, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and the optional treatment, plus any copayment for the covered benefit.

   If an cast metal partial denture will restore the case, the Contract Dentist will apply the difference of the cost of such procedure toward a more complicated precision appliance which the Enrollee and dentist may choose to use. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and the optional treatment plus any copayment for the covered benefit.

   An acrylic partial denture may be considered a covered benefit in cases involving extensive periodontal disease. Enrollee shall pay the applicable copayment for an cast metal partial denture.

2. COMPLETE DENTURES

If, in the construction of a denture, the Enrollee and the Contract Dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Full upper and/or lower dentures are not to exceed one each in any five-year period. The Enrollee is entitled to a new upper or lower denture only if the existing denture is more than five years old and cannot be made satisfactory by either reline or repair.

3. FILLINGS AND CROWNS

Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

Porcelain or porcelain fused to metal crowns on all molars are considered optional treatment. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

The DeltaCare USA program provides amalgam and resin restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional, and if provided, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

A restoration is a covered benefit only when required for restorative reasons (radiographic evidence of decay or missing tooth structure). Restorations placed for any other purposes including but not limited to cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth, or the anticipation of future fractures, are not covered benefits.

Composite resin restorations in posterior teeth are considered optional treatment. If provided, the Enrollee must pay the

difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. An allowance will be made for an acrylic crown. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

A crown placed on a specific tooth is allowable only once in a five-year period.

A pulp cap is a benefit only on a permanent tooth with an open apex.

4. FIXED BRIDGES

A fixed bridge is considered standard dental treatment when it is necessary to replace one missing permanent anterior tooth in a person 16 years old or older. Such treatment will be covered if the Enrollee's oral health and general dental condition permits.

Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered optional dental treatment. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Fixed bridges are not a benefit when provided in connection with a partial denture on the same arch. If provided, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Replacement of an existing nonfunctional bridge is limited to once in a five-year period from initial placement and shall be covered only when the replacement duplicates the original bridge.

Fixed bridges are not a benefit for Enrollees under the age of 16. A fixed bridge under these circumstances is considered optional dental treatment. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

5. RECONSTRUCTION

   The DeltaCare USA program provides coverage for procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) are not covered benefits. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework is considered full mouth reconstruction and is not a benefit of the DeltaCare USA program. The program will allow for complete or partial denture(s).

6. SPECIALIZED TECHNIQUES

   Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization, are all considered optional treatment. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

7. PREVENTIVE CONTROL PROGRAMS

   Any part of a preventive or soft tissue management program, which is not a listed covered service on Schedule A.

8. STAYPLATES

   Stayplates in conjunction with fixed or removable appliances, are only a benefit to replace extracted anterior teeth for adults during a healing period and as anterior space maintainers for children.

9. FRENECTOMY

   The frenum can be excised when the tongue has limited mobility; or has a large diastema between teeth; or when the frenum interferes with a prosthetic appliance.

10. PEDODONTIA

    Pedodontic referrals must be preauthorized by Delta Dental. Benefits for dependent children through age three are covered at 100% of the agreed upon fee less any applicable copayments for covered benefits and children four years and older are at 50% of agreed upon fee less any applicable copayments for covered services.

11. TREATMENT PLANNING

    The objective of this Program is to see that all Enrollees are brought to a good level of oral health and that this level of oral health is maintained. To achieve this objective takes careful treatment planning. Priorities have been established on the following basis:

    a. Priority attention is given to those procedures that, if not done first, could have an immediate effect on the Enrollee's overall oral health.
    b. Priority is next given to work such as active dental decay and periodontal problems that would not have an immediate effect on the Enrollee's oral health.
    c. Priority is then given to replacement of missing teeth not causing a gross lack of function.

    Exceptions are made to this treatment planning concept based on individual circumstances.

DELTA DENTAL®

Non-Discrimination Disclosure

Discrimination is Against the Law

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

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

if such denial or limitation results in discriminating against a transgender individual.

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

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

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

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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)

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 수 있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-800-422-4234 (TTY: 711)번으로 연락하십시오. (Korean)

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

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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)

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)

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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

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