DeltaCare® USA

Dental Health Care Plan

Evidence of Coverage

The Boeing Company
IAM

Provided by:

ALPHA Dental Programs, Inc.
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

Administered by:

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

deltadentalins.com

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

The Boeing Company
IAM 837 - Active

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

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

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

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

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

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

Certificate of Coverage
Introduction

DeltaCare® USA Dental Health Care Plan

This Certificate of Coverage ("COC") provides information about Your DeltaCare USA Dental Health Care Plan ("Plan") provided by Alpha Dental Programs, Inc., ("Company"), on behalf of itself, and its affiliated companies. To offer these Benefits, the Contractholder has entered into a Group Dental Insurance 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.

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").

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 COC and the attachments are subject to all provisions of the Contract. In the event there is a conflict between the COC 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
This COC is a summary of Your dental Plan. This information is not a guarantee of covered Benefits, services or payments.

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

You must obtain dental Benefits from Your 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.

Authorization: The process by which We determine if a procedure or treatment is a referable Benefit under Your Plan.

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

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

Contract Dentist: A Dentist who provides services in general dentistry and who has agreed to provide Benefits under this Plan. Contract Dentists may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services. Referrals for Specialist Services must be obtained from Your Contract Dentist.

Contract Orthodontist: A Dentist who specializes in orthodontics and who has agreed to provide Benefits under this Plan. Services obtained from a Contract Orthodontist must be referred by Your Contract Dentist.

Contract Specialist: A Dentist who provides Specialist Services and who has agreed to provide Benefits under this Plan. Services obtained from a Contract Specialist must be referred by Your Contract Dentist.

Contract Year: Period of twelve (12) months starting on the Contract's Effective Date and or the anniversary of the Effective Date and each subsequent 12 month period thereafter.

Contract Term: The period during which coverage is in effect whether on a Calendar or Contract Year.

Contractholder: The group that enters into or executes this Contract to obtain dental coverage.

Copayment: The amounts set forth in *Schedule A - Description of Benefits and Copayments* that You are responsible to pay the treating Dentist. Copayments must be paid at the time treatment is received.

Dependents ("Dependent Enrollees"): The Primary Enrollee's eligible Dependents and any Individuals eligible to enroll for Benefits because of their relationship with the Primary Enrollee. And includes:

- The Spouse
- Dependent children from birth to age 26 regardless of marital status
- As otherwise required by state or federal law.

Children include natural children, stepchildren, foster children, grandchildren, adopted children, children placed for adoption and children of a partner as recognized by the Contractholder.

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

Effective Date: The date the Contract or coverage begins.

Emergency Services: Dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing You in serious jeopardy. Emergency dental care is limited to palliative treatment for the elimination of dental pain.

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

Grace Period: A period of no less than 31 days after the Premium payment is due under the Contract, in which a payment may be made and during which coverage will continue in effect, subject to the Premium payment by the end of the Grace Period.

Open Enrollment Period: The period the Contractholder has established for You to make changes in coverage selections for the next Contract Term.

Optional Treatment: Any alternative procedure that satisfies the same dental need as a covered procedure and is chosen by You subject to the limitations and exclusions described in the Schedules attached to this COC.

Out-of-Network: Treatment by a Dentist who has not signed a contract with Us to provide Benefits under this Plan. Also referred to as Non-participating Dentist.

Plan: Dental Benefits selected by the Contractholder and provided under the Contract, COC and any attachments.

Premium: Payment made in consideration of dental coverage.

Schedules: Dental services and procedures and applicable limitations and exclusions included under Your Plan and described in:
- *Schedule A, Description of Benefits and Copayments,* and
- *Schedule B, Limitations and Exclusions of Benefits*

Special Enrollment Period: The period of time outside Your Open Enrollment Period during which individuals eligible as Primary Enrollees or Dependents who experience certain qualifying events may enroll in this Plan.

Specialist Services: Services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics or pediatric dentistry. Specialist Services must be referred by a Contract Dentist.

Spouse: An individual who is a partner of the Primary Enrollee as:
- Defined and as may be required to be treated as a Spouse by the laws of the state where the Contract is issued and delivered;
- Defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides; or
- May be recognized by the Contractholder.

Eligibility and Enrollment - When Coverage Begins

Eligibility Requirements

The Contractholder is responsible for establishing eligibility and reporting enrollment to Us. We process enrollment as reported. You are eligible to enroll if You meet the eligibility requirements defined by the Contractholder.

Eligibility is determined by the Contractholder. We do not make eligibility determinations. We will update Our files to record the eligibility information provided by the Contractholder or its designee.

Your Dependents are eligible to enroll on the same date that You enroll. Later-acquired Dependents become eligible as soon as they acquire dependent status.

Eligibility may be delayed for young children, under the age of 4, until the beginning of any Contract Term immediately following the child's birthday. For coverage to begin on young children, the eligibility notice and additional Premium payment must be received by Us within 30 days of the beginning of the Contract Term immediately following the child's birthday.

Children/students must be dependent upon You for support and maintenance.

There is no coverage under this Plan for Dependents on active military duty.

Medicare eligibility will not affect Your eligibility or Your Dependent's eligibility, if applicable.

Overage Children

An overage dependent child is eligible if:
- The child is incapable of self-sustaining employment because of a physically or mentally impairment that began prior to reaching the limiting age;
- The child is chiefly dependent on the Primary Enrollee for support; and
- Proof of disability is provided within 31 days of request. Proof of disability will not be required more than one (1) time per year following a two year period after the Dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Primary Enrollee for support because of a physically or intellectually disabling injury, illness or condition that began before the Dependent reaches the limiting age.

Enrollment Requirements
If the Contractholder is responsible for Your Premium, coverage will begin on the Contract's Effective Date.

If You are responsible for Your Premium:
- All Dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period or Special Enrollment Period.
- If You elect Dependent coverage, You must enroll all of Your Dependent Enrollees for coverage.

An exception for enrolling Dependent Enrollees within 30 days after they become eligible applies for certain young children. The

eligibility date for such children may be delayed as outlined in the *Eligibility Requirements* section.

You:
- Must pay Premiums in the manner elected by the Contractholder and approved by Us, and
- May not drop coverage and may only make coverage changes during an Open Enrollment Period or Special Enrollment Period as a result of a qualifying status change.

A Dependent may not be enrolled under more than one Primary Enrollee.

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

Special Enrollment Periods - Enrollment Changes
After Your Effective Date, You may change Your enrollment during a Special Enrollment Period as a result of a qualifying status change. Qualifying status change include, but are not be limited to, the following events:
- Marital status (Examples include, but are not limited to: marriage, divorce, legal separation, annulment or death);
- Number of Dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- Dependent child ceases to satisfy eligibility requirements;
- Employment status (change in Your or Your Dependent's employment status;
- Residence (You move);
- Court order requiring Dependent coverage;
- Loss of other group coverage;
- Any other current or future election changes permitted by Internal Revenue Code Section 125; or
- Any other changes specified by applicable law or regulation.

Premiums
You are required to contribute towards the cost of Your coverage and the cost of Your Dependent's coverage, if applicable.

How to Use the DeltaCare USA Program

Choice of Contract Dentist
We will provide Your Plan with Contract Dentists at convenient locations. Upon enrollment, You must select a Contract Dentist from the list of Dentists provided at deltadentalins.com. If the Contract Dentist You selected becomes unavailable, We will request You make a selection to another Contract Dentist. If You fail to select a Contract Dentist, the first Contract Dentist You visit will become Your selected Dentist following Your first routine visit.

You may change Your Contract Dentist online or by contacting Customer Service at 800-422-4234. Selections made by the 15th of the month are effective immediately. Selections made on or after the 16th of the month will be effective on the first day of the following month.

We will request You select another Contract Dentist provided Your Contract Dentist:

- Is no longer taking further enrollment;
- No longer participates in the Plan; or
- Requests, for good cause, that You or Your Dependents select another Contract Dentist.

Any dental treatment in progress must be completed before You change to another Contract Dentist. For example, dental treatment may include:

- Partial or full dentures for which final impressions have been taken.
- All work on any tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Contract Dentist Termination
Services for Benefits must be provided by Your Contract Dentist. Specialist Services, obtained from a Contract Orthodontist or Contract Specialist, must be referred by Your Contract Dentist.

We have no obligation or liability with respect to services provided by Out-of-Network Dentists, with the exception of Emergency Services or Specialist Services referred by a Contract Dentist and authorized by Us. All authorized Specialist Services claims will be paid less any applicable Copayments.

Contract Dentist Termination
If Your Contract Dentist no longer participates in this Plan, the Contract Dentist will complete all treatment in progress as described above.

Upon termination of a Contract Dentist's agreement, We will be liable for the completion of dental treatment begun prior to the termination of the agreement. For example, the terminating Contract Dentist will complete:

- A partial or full denture for which final impressions have been taken; or
- All work on any tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

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

Benefits, Limitations and Exclusions
This Plan provides Benefits and any applicable Copayments, deductibles, annual maximums and waiting periods as shown in the attached *Schedules*. Only services, supplies or procedures listed in the *Schedules* and deemed appropriate by Your Contract Dentist are covered under this Plan. Contract Dentists may provide services directly 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*.

Should We fail to pay a Contract Dentist, You will not be liable to that Dentist for any sums owed by Us. If You have not received Authorization for treatment from an Out-of-Network Dentist, and We fail to pay that Out-of-Network Dentist, You may be liable to

that Dentist for the cost of services. For further clarification, see *"Emergency Services"*.

Emergency Services
If you have a dental emergency, You should contact Your Contract Dentist whenever possible. Contract Dentists maintain a twenty-four (24) hour Emergency Services system seven (7) days a week. If You are unable to reach Your Contract Dentist for Emergency Services, contact Customer Service at 800-422-4234 for assistance in obtaining urgent care.

You may seek treatment from a Dentist other than Your Contract Dentist with no referral during non-business hours, or if You require Emergency Services and are 35 miles or more from Your Contract Dentist. You are only responsible for the Copayment(s) for any treatment received relating to the emergency.

Benefits for Emergency Services not provided by a Contract Dentist are limited to a maximum of $100.00 per emergency, per Enrollee, less the applicable Copayment. If this maximum is exceeded, You are responsible for any charges for services by a Dentist other than Your Contract Dentist. You must return to Your Contract Dentist for any necessary follow-up care.

Specialist Services
Specialist Services for oral surgery, endodontics, orthodontics, periodontics or pediatric dentistry must be referred by Your Contract Dentist.

If You require Specialist Services and there is no Contract Orthodontist or Contract Specialist to provide these services within 35 miles of Your home, the Contract Dentist must receive Authorization from Us to refer You to an Out-of-Network orthodontist or Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network orthodontist or Out-of-Network specialist that are not authorized by Us are not covered.

Claims for Reimbursement
Claims for covered Emergency Services or Specialist Services should be submitted for payment within 90 days of receiving treatment. Claims must be received within one (1) year of treatment date. The address for claims submission is:

Claims Department
P.O. Box 1810

Alpharetta, GA 30023

Notice of Claim
In the case of Emergency or Specialist Services, written notice of claim must be given to the Us within twenty days after the occurrence or commencement of any loss covered by the Contract, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the You or the beneficiary to Claims Department, P.O. Box 1810, Alpharetta, GA 30023, or to any other authorized agent, with information sufficient to identify the insurer, will be deemed notice to Us.

Claim Forms
We, upon receipt of a notice of claim, will furnish to You such forms as are usually furnished by it for filing proofs of loss. If claim forms are not furnished within 15 days after the giving of notice, You will be deemed to have complied with the requirements of the COC as to proof of loss upon submitting, within the time fixed in this COC for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Time Payment of Claims
Indemnities payable for any loss other than loss for which this Contract provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Contract provides periodic payment will be paid no less frequently than monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims
Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity will be payable to the estate of the insured. Any other accrued indemnities unpaid at Your death may, at Our option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to You.

Coordination of Benefits
If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, Benefits will be coordinated. If this plan is the "primary" plan, We will not reduce Benefits. If this plan is the "secondary" plan, We may

reduce Benefits so that the total Benefits Paid or provided by all plans do not exceed 100% of total allowable expense.

But if this plan is the "secondary" plan, We determine Benefits after those of the primary plan and will pay the lesser of the amount that We would pay in the absence of any other dental benefit coverage or Your total out-of-pocket cost under the primary plan for Benefits covered under Your Plan.

In Order to determine which Plan is primary, We will use the following rules.

- The plan covering You as an employee or Primary Enrollee is primary over a plan covering You as a dependent.
- The plan covering You as an employee is primary over a plan covering You as a dependent; except that if You are also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    * Secondary to the plan covering You as a dependent; and
    * Primary to the plan covering You as other than a dependent (e.g. a retired employee), then the Benefits of the plan covering You as a dependent are determined before those of the plan covering You as other than a dependent.
- Except as stated in the immediate above paragraph, when this plan and another plan cover the same child as a dependent of different persons, referred to as parents:
    * The Benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
    * If both parents have the same birthday, the Benefits of the plan covering one parent longer are determined before those of the plan covering the other parent for a shorter period of time.
    * However, if the other plan has no birthday rule, but has a rule based on the gender of the parent, and as a result, the plans do not agree on the order of Benefits, the rule in the other plan determines the order of Benefits.
- In the case of a dependent child of legally separated or divorced parents, the plan covering the child as a dependent of the parent with legal custody or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the child as a dependent of the parent without legal custody.
- If there is a court decree establishing financial responsibility for the child's health care expenses, the Benefits of a plan covering the child as a dependent of the parent with financial

responsibility will be determined before the Benefits of any other policy covering the child as a dependent child.

- If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the child's health care expenses, the plans covering the child will follow the order of Benefit determination rules outlined above.
- The Benefits of a plan covering You as an employee who is neither laid-off nor retired are determined before those of a plan covering You as a laid-off or retired employee. The same holds true if You are a dependent of a Primary Enrollee as a retiree or an employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- If Your coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination.
    * First, the Benefits of a plan covering the Enrollee as an employee or Primary Enrollee (or the Primary Enrollee's dependent).
    * Second, the Benefits under the continuation coverage.
    * If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- If none of the above rules determines the order of Benefits, the Benefits of the plan covering an employee longer are determined before those of the plan covering that insured person for the shorter term. When determination cannot be made in accordance with the rules above, the Benefits of a plan that is a medical plan covering dental as a Benefit will be primary to a standalone dental plan.

Enrollee Complaint Procedure

We will provide notification when 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 Customer Service at 800-422-4234 or a written complaint may be submitted to:

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

Written complaints must include, at a minimum the following information:

- Patient's name
- Primary Enrollee's name, address, telephone number and identification number
- Contractholder's name
- Treating Dentist's name and location.

Adverse Determinations
Utilization review decisions are conducted by licensed Dentists in accordance with standards developed with input from a Dentist of the appropriate specialty. We use written medically/dentally acceptable screening criteria and review procedures that are established and periodically evaluated and updated with appropriate involvement from Dentists, including practicing Dentists, and other health care providers.

Pre-Authorization (Pre-Service) and Concurrent Reviews

We do not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Additionally, We do not conduct concurrent review relating to continued or extended dental services, or additional services for an insured undergoing a course of continued treatment.

Unlike medical coverage, it is unlikely that a life-threatening situation should arise, or even more unlikely due to the nature of dental care that You would need to receive authorization for an extended hospital stay or medical treatment. If You must seek emergency dental treatment, You do not need to obtain pre-authorization to seek services.

We do not make Adverse Decisions on urgent or emergency dental services

Retrospective (Post-Service) Reviews

Adverse Decisions are rendered after dental services are delivered.

Internal Review Procedure: Adverse Determinations

"Necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim),

You or Your authorized representative must file a request for review, referred to as 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 during the initial benefit determination. The review will be conducted by a person other than the individual who made the original benefit determination, or the individual's subordinate.

Upon request and free of charge, You or Your authorized representative will be provided 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 (dental) necessity, experimental treatment or a clinical judgment in applying the terms of the Plan, 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 made available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations the quality management coordinator will provide You or Your authorized representative an acknowledgment of receipt of the complaint. Certain complaints may require that You be referred to a Dentist for a clinical evaluation of the dental services provided.

We will make a determination, in writing, within 30 days of receipt of of all necessary information relating to the 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 in making such a review. A written response will be provided to You or Your authorized representative within 30 days after receipt of Your appeal and all necessary information or a written explanation if additional time is required to issue the results.

Reconsideration
A treating Dentist has the opportunity to request, on Your behalf, in the case of an initial decision, reconsideration of an adverse determination. The reconsideration must occur within one (1)

working day of the receipt of the request and must be conducted between the Dentist rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer does not resolve the difference of opinion, the adverse determination may be appeals by You or the Dentist on Your behalf. Reconsideration is not a prerequisite to an appeal of an adverse determination.

The Missouri Department of Commerce Insurance ("Department") is responsible for regulating Prepaid Dental Plans. If You have a complaint against Your dental Plan, You should first contact Your dental Plan at 800-422-4234 and use Your dental Plan's complaint process before contacting the Department. Utilizing this complaint procedure does not prohibit any potential legal rights or remedies that may be available to You. If You need help with a complaint involving an emergency, a complaint that has not been satisfactorily resolved by Your dental Plan, or a complaint that has remained unresolved for more than 30 days, You may call the Department for assistance. The Department may be reached at:

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

If Your Plan is subject to 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 Your rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The US Department of Labor may be contacted at:

U.S. Department of Labor
Employee Benefits Security Administration (EBSA)
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Renewal and Termination of Benefits

This Plan renews on the anniversary of the Contract unless We provide notice of a change in Premiums or Benefits and the Contractholder does not accept the change. Your Benefits will terminate:

- As of the date that this Plan is terminated,
- You cease to be eligible under the terms of this Plan, or
- Your enrollment is canceled under the terms of this Plan.

We are not obligated to continue to provide Benefits to You or Your Dependents except for completion of dental treatment started when this Plan was in effect.

Cancellation of Enrollment
Subject to the *Continuation of Coverage under USERRA* and *Continuation of Coverage under COBRA* provisions, Your enrollment may be canceled, or renewal of enrollment refused, in the following events:

Immediately:

a) upon loss of eligibility as described in this Certificate of Coverage; or

- If You engage in conduct detrimental to safe operations and the delivery of services while receiving services from a Contract Dentist.

Upon 15 days written notice if:

- The Premiums are not paid by, or on behalf of You, on the date due. However, You may continue to receive Benefits during the Grace Period and may be reinstated during the term of the Contract upon payment of any unpaid Premium; or
- You knowingly commit or permit another person to commit fraud or deception in obtaining Benefits under this Plan.

Upon 30 days written notice if:

- the Contract is terminated or not renewed;
- You fail to pay Copayments. However, You may be reinstated during the term of the Contract upon payment of all delinquent charges; or
- A satisfactory dentist-patient relationship fails to be established with multiple Contract Dentists. We must show that We have, in good faith, provided You with an opportunity to select an alternative Contract Dentist. If You establish a history of unsatisfactory relationships, We will notify You in writing, at least 30 days in advance, that We consider the dentist-patient relationship 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.

The Contractholder will provide You with 15 days advance notice prior to cancellation or discontinuance of the Plan.

Cancellation of Your enrollment will automatically cancel the enrollment of any of Your Dependent Enrollees.

General Provisions

Compliance with Administrative Simplification, Security and Privacy Regulations
The parties will comply in all respects with applicable federal, state and local laws and regulations relating to administrative simplification, security and privacy of individually identifiable information including executing any agreements as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The parties agree that this Contract will incorporate terms as necessary and as applicable to execute the required agreements (i.e. business associate agreement) to comply with federal regulations issued under the HIPAA and HITECH Act or to comply with any other enacted administrative simplifications, security or privacy laws or regulations.

Conformity With Prevailing Laws
All legal questions about the Contract will be governed by the state where the Contract was entered into and is to be performed. Any part of the Contract which conflicts with state or federal law is hereby amended to conform to the minimum requirements of such laws.

Entire Contract; Changes
This Contract, including the COC, Schedules and any Attachments, is the entire agreement between the parties. No agent has authority to change or waive any of its provisions. Changes are not valid unless approved by one of Our executive officers.

Incontestability
After this Contract has been in force for 2 years from the Effective Date, no statement made by the Contractholder will be used to void this Contract. No statement by an employee or You with respect to Your insurability will be used to reduce or deny a claim or contest the validity of insurance for You after that person's coverage has been in effect 2 years or more during the Your lifetime, unless the statement is contained in a written instrument signed by the person making such statement.

No claims for loss incurred or disability commencing after 2 years from the date of issue of the Contract will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed prior to the Effective Date of this Contract.

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

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

Processing Policies
The *Schedules* explain the services covered under the Plan. Contract Dentists, Contract Orthodontists and Contract Specialists use professional judgment to determine appropriate services for You. Benefits performed by Contract Dentists, Contract Orthodontists and Contract Specialists are provided subject to any Copayments. You may contact Our Customer Service at 800-422-4234 for information regarding the dental care guidelines for DeltaCare USA.

Severability
If any part of the Contract, this COC, Attachments or an amendment to any of these documents is found by a court or other authority to be illegal, void or not enforceable, all other portions of these documents will remain in full force and effect.

Strike, Lay-off and Leave of Absence
You will not be covered for any dental services received while on strike, lay-off or leave of absence, other than as required under the Family & Medical Leave Act of 1993 (FMLA) or other applicable state or federal law*.

*Your coverage is not affected if You take a leave of absence under the FMLA or other applicable state or federal law. If You are currently paying any part of the Premium, You may choose to continue coverage. If You do not continue coverage during the leave, coverage may be resumed upon their return to active work as if no interruption occurred.

Important: FMLA does not apply to all organizations, only those that meet certain size guidelines. Refer to Your Human Resources unit for complete information.

Continuation of Coverage under USERRA
As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), if You are covered on the date Your USERRA leave of absence begins, You may continue dental coverage for Yourself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of:

- Twenty-four (24) months, beginning on the date the leave of absence begins, or;
- The date You fail to return to work within the time required by USERRA.

For USERRA leave that extends beyond 31 days, the Premium for continuation of coverage will be the same as for COBRA coverage.

Continuation of Coverage under COBRA
The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides a way for You to continue coverage for a period of time when employer coverage is lost. COBRA does not apply to all companies, only those that meet certain size guidelines. See Your Human Resources Department or website for complete information. We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

Non-Discrimination
We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We:

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

- Information written in other languages

If you need these services, contact Customer Service at 800-471-9925.

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
18000 Studebaker Road, Suite 530
Cerritos, CA 90703
Telephone Number: 800-471-9925
Website Address: deltadentalins.com

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

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

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

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the Contract Dentist subject to the *Limitations and Exclusions* of the Plan. Please refer to *Schedule B* for further clarification of Benefits. **You should discuss all treatment options with Your 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-2025 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	
	- Radiographic images (x-ray) copayment applies to the assigned general dentist only. If additional radiographic images are required from a specialist, additional fees may apply.	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	$5.00
D0210	Intraoral - comprehensive series of radiographic images - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted.*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost

D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0330	Panoramic radiographic image - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*	No Cost
D0396	3D printing of a 3D dental surface scan	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	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

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *2 per 12 month period*	No Cost
D1120	Prophylaxis *cleaning* - child - *2 per 12 month period*	No Cost
D1206	Topical application of fluoride varnish - *child to age 19; 2 D1206 or D1208 per 12 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 2 D1206 or D1208 per 12 month period*	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	No Cost
D1516	Space maintainer - fixed - bilateral, maxillary	No Cost

D1517	Space maintainer - fixed - bilateral, mandibular	No Cost
D1520	Space maintainer - removable - unilateral - per quadrant	No Cost
D1526	Space maintainer - removable - bilateral, maxillary	No Cost
D1527	Space maintainer - removable - bilateral, mandibular	No Cost
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
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	No Cost

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces (anterior)	No Cost
D2391	Resin-based composite - one surface, posterior	No Cost
D2392	Resin-based composite - two surfaces, posterior	No Cost
D2393	Resin-based composite - three surfaces, posterior	No Cost
D2394	Resin-based composite - four or more surfaces, posterior	No Cost
D2740	Crown - porcelain/ceramic	$295.00
D2750	Crown - porcelain fused to high noble metal	$295.00
D2751	Crown - porcelain fused to predominantly base metal	$195.00

D2752	Crown - porcelain fused to noble metal	$235.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$295.00
D2790	Crown - full cast high noble metal	$260.00
D2791	Crown - full cast predominantly base metal	$160.00
D2792	Crown - full cast noble metal	$200.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2976	Band stabilization - per tooth - *limited to once in a lifetime per tooth*	No Cost

D3000-D3999 IV. ENDODONTICS

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

D3348	Retreatment of previous root canal therapy - molar	No Cost
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	No Cost
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	No Cost
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	No Cost
D3410	Apicoectomy - anterior	No Cost
D3421	Apicoectomy - premolar (first root)	No Cost
D3425	Apicoectomy - molar (first root)	No Cost
D3426	Apicoectomy (each additional root)	No Cost
D3430	Retrograde filling - per root	No Cost
D3450	Root amputation - per root	No Cost

D4000-D4999 V. PERIODONTICS

- 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	$31.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$10.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$33.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$33.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$114.00

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

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first three months after placement. You must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

- Copayments include additional lab fee.

D5110	Complete denture - maxillary	$215.00
D5120	Complete denture - mandibular	$215.00
D5130	Immediate denture - maxillary	$235.00
D5140	Immediate denture - mandibular	$235.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$195.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$195.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$240.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$240.00

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 ...	$290.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$290.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$290.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$290.00
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	$195.00
D5283	Removable unilateral partial denture - one piece cast metal (including rententive/clasping materias, rests, and teeth), mandibular	$195.00
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant	$195.00
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant	$195.00
D5410	Adjust complete denture - maxillary	No Cost
D5411	Adjust complete denture - mandibular	No Cost
D5421	Adjust partial denture - maxillary	No Cost
D5422	Adjust partial denture - mandibular	No Cost
D5511	Repair broken complete denture base, mandibular .	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture - per tooth	$30.00
D5611	Repair resin partial denture base, mandibular	$65.00
D5612	Repair resin partial denture base, maxillary	$65.00
D5621	Repair cast partial framework, mandibular	$60.00
D5622	Repair cast partial framework, maxillary	$60.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$60.00
D5640	Replace missing or broken teeth - partial denture - per tooth	$40.00
D5650	Add tooth to existing partial denture - per tooth	$40.00
D5660	Add clasp to existing partial denture - per tooth	$60.00

D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$40.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$40.00
D5710	Rebase complete maxillary denture	$70.00
D5711	Rebase complete mandibular denture	$70.00
D5720	Rebase maxillary partial denture	$70.00
D5721	Rebase mandibular partial denture	$70.00
D5725	Rebase hybrid prosthesis	$70.00
D5730	Reline complete maxillary denture (chairside)	$65.00
D5731	Reline complete mandibular denture (chairside)	$65.00
D5740	Reline maxillary partial denture (chairside)	$65.00
D5741	Reline mandibular partial denture (chairside)	$65.00
D5750	Reline complete maxillary denture (laboratory)	$75.00
D5751	Reline complete mandibular denture (laboratory)	$75.00
D5760	Reline maxillary partial denture (laboratory)	$75.00
D5761	Reline mandibular partial denture (laboratory)	$75.00
D5765	Soft liner for complete or partial removable denture - indirect	$75.00
D5810	Interim complete denture (maxillary)	$95.00
D5811	Interim complete denture (mandibular)	$95.00
D5820	Interim partial denture (including retentive/ clasping materials, rests, and teeth), maxillary - *limited to 1 in any 12 consecutive months*	$95.00
D5821	Interim partial denture (including retentive/ clasping materials, rests, and teeth), mandibular - *limited to 1 in any 12 consecutive months*	$95.00
D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

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

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

D6210	Pontic - cast high noble metal	$260.00
D6211	Pontic - cast predominantly base metal	$160.00
D6212	Pontic - cast noble metal	$200.00
D6240	Pontic - porcelain fused to high noble metal	$295.00
D6241	Pontic - porcelain fused to predominantly base metal	$195.00
D6242	Pontic - porcelain fused to noble metal	$235.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$80.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$80.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$80.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$80.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$80.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$80.00
D6606	Retainer inlay - cast noble metal, two surfaces	$80.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$80.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$80.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$80.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$80.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$80.00

D6612	Retainer onlay - cast predominantly base metal, two surfaces	$80.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$80.00
D6614	Retainer onlay - cast noble metal, two surfaces	$80.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$80.00
D6740	Retainer crown - porcelain/ceramic	$295.00
D6750	Retainer crown - porcelain fused to high noble metal	$295.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$195.00
D6752	Retainer crown - porcelain fused to noble metal	$235.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$295.00
D6780	Retainer crown - 3/4 cast high noble metal	$260.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$160.00
D6782	Retainer crown - 3/4 cast noble metal	$200.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$295.00
D6784	Retainer crown - 3/4 titanium and titanium alloys	$260.00
D6790	Retainer crown - full cast high noble metal	$260.00
D6791	Retainer crown - full cast predominantly base metal	$160.00
D6792	Retainer crown - full cast noble metal	$200.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	$60.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes 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	No Cost

D7240	Removal of impacted tooth - completely bony	No Cost
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	No Cost
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7252	Partial extraction for immediate implant placement - *Once in a lifetime*	No Cost
D7284	Excisional biopsy of minor salivary glands - *does not include pathology laboratory procedures*	No Cost
D7285	Incisional biopsy of oral tissue-hard (bone, tooth) ..	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	No Cost
D7410	Excision of benign lesion up to 1.25 cm	No Cost
D7411	Excision of benign lesion greater than 1.25 cm	No Cost
D7412	Excision of benign lesion, complicated	No Cost
D7413	Excision of malignant lesion up to 1.25 cm	No Cost
D7414	Excision of malignant lesion greater than 1.25 cm ...	No Cost
D7415	Excision of malignant lesion, complicated	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7520	Incision and drainage of abscess - extraoral soft tissue	No Cost
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

- 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 - comprehensive series of radiographic images - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*

D0322 Tomographic survey

D0330 Panoramic radiographic image - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*

D0340 2D cephalometric radiographic image - acquisition, measurement and analysis

D0350 2D oral/facial photographic images obtained intra-orally or extra-orally

D0396 3D printing of a 3D dental surface scan

D0470 Diagnostic casts

D0801 3D intraoral surface scan - direct

D0802 3D dental surface scan - indirect

D0803 3D facial surface scan - direct

D0804 3D facial surface scan - indirect

The Benefit for post-treatment records includes: $70.00

D0210 Intraoral - comprehensive series of radiographic images - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*

D0470 Diagnostic casts

D8070 Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* $2,750.00

D8080 Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* $2,750.00

D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$2,975.00
D8091	Comprehensive orthodontic treatment with orthognathic surgery - *adults, including covered dependent adult children*	$3,430.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8670	Periodic orthodontic treatment visit - *included in comprehensive case fee*	No Cost
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery - *included in comprehensive case fee*	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative treatment of dental pain - per visit	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	No Cost
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	No Cost
D9239	Intravenous moderate (conscious) sedation/ analgesia - first 15 minutes	No Cost
D9243	Intravenous moderate (conscious) sedation/ analgesia - each subsequent 15 minute increment	No Cost
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	No Cost
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	No Cost

D9951	Occlusal adjustment, limited	No Cost
D9952	Occlusal adjustment, complete	No Cost
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 Contract Dentist, You pay the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services and are referred by the Contract Dentist must be authorized by Us. You pay the Copayment(s) specified for such services.

SCHEDULE B

Limitations and Exclusions of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions (Procedures D7230, D7240, and D7241).
3. Benefits provided by a pediatric Dentist are limited to children through age 13 following an attempt by the 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.
4. The cost to You for receiving orthodontic treatment when coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's submitted fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. You make payment directly to the Contract Orthodontist as arranged.
5. Orthodontic treatment in progress is available to You, if at the time of Your original effective date, You are in active treatment started under Your previous group 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 Your prior dental plan. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   * has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   * is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered Benefits.
10. Dental services received from any dental facility other than a 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 conditions arising out of and due to employment for which Workers' Compensation is payable. Services which are provided by state government or agency thereof, or are provided without cost by any municipality, county or other subdivision.
14. Extensive treatment plans involving six (6) or more crowns or units of fixed bridgework (major mouth reconstruction).
15. Dental expenses incurred in connection with any dental or orthodontic procedure started before Your eligibility with the DeltaCare USA Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
16. Lost, stolen or broken orthodontic appliances.
17. Changes in orthodontic treatment necessitated by accident of any kind.
18. Extractions solely for the purpose of orthodontics.
19. Myofunctional and parafunctional appliances and/or therapies.
20. Treatment or appliances that are provided by a Contract Dentist whose practice specializes in prosthodontic services.
21. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.

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)

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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 איִך העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אַז איר קענט באַקומען דעם דאָזיקן דאָקומענט אין אייִער שפּראַך. פֿאַר אומזיסטע הילף קענט איר אָנרופֿן 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