



Delta Dental of Pennsylvania

**THE JOHNS HOPKINS UNIVERSITY –
STUDENT PLAN**



deltadentalins.com

Group No: 19397

Effective Date: August 15, 2018

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INTRODUCTION

We are pleased to welcome you to the group dental plan for The Johns Hopkins University – Student Plan. Your plan is underwritten and administered by Delta Dental of Pennsylvania (“Delta Dental”), a not-for-profit dental service company. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the Provider, but to see him/her on a regular basis.

Using This Evidence of Coverage

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

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

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

Contact Us

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

You can access our automated information line at 800-932-0783 during regular business hours to obtain information about Enrollee eligibility and benefits, group benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write us with your question(s), please mail your inquiry to the following address:

*Delta Dental of Pennsylvania
P.O. Box 2105
Mechanicsburg, PA 17055-2105*



Anthony S. Barth, President & CEO

DEFINITIONS

Terms when capitalized in your Evidence of Coverage booklet have defined meanings, given in the section below or throughout the booklet sections.

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

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

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

Claim Form: the standard form used to file a claim or request Pre-Treatment Estimate.

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

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

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

Contract Year: the 12 months starting on the Effective Date and each subsequent 12 month period thereafter. Deductibles and Maximums will be determined using this 12 month period rather than on a Calendar Year basis.

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

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

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

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

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

Dependent Enrollee: an Eligible Dependent enrolled to receive Benefits.

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

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

Eligible Employee: any employee as eligible for Benefits.

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

Enrollee Pays: Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Delta Dental Pays" on the claims statement when a claim is processed.

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

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

Maximum Contract Allowance: the reimbursement under the Enrollee’s benefit plan against which Delta Dental calculates its payment and the Enrollee’s financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by a PPO Provider is the lesser of the Provider’s Submitted Fee or the Delta Dental PPO Contracted Fee.
- by a Premier Provider is the lesser of the Provider’s Submitted Fee or the Delta Dental Premier Contracted Fee.
- by a Non-Delta Dental Provider is the lesser of the Provider’s Submitted Fee or the Program Allowance.
- by a PPO Provider is the lesser of the Provider’s Submitted Fee or the Delta Dental PPO Contracted Fee or the amount shown on the Table of Allowances.
- by a Premier Provider is the lesser of the Provider’s Submitted Fee or the Delta Dental Premier Contracted Fee or the amount shown on the Table of Allowances.
- by a Non-Delta Dental Provider is the lesser of the Provider’s Submitted Fee or the amount shown on the Table of Allowances.

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

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

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

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

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

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

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

Qualifying Status Change: a change in:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child’s birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- employment status (change in employment status of Enrollee or Eligible Dependent);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee, dependent Spouse or child moves);
- a court order requiring dependent coverage; or
- any other current or future election changes permitted by Internal Revenue Code Section 125.

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

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

- as defined and as may be required to be treated as a Spouse by the laws of the state where the Contract is issued and delivered;

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

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

PREMIUMS

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

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

We may cancel the Contract 30 days after written notice to the Contractholder if monthly premiums are not paid when due.

ELIGIBILITY AND ENROLLMENT

Eligibility Requirements

You will become eligible to receive Benefits on the date stated in the Contract after completing any eligibility periods required by the Contractholder as stated in the Contract.

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

- Dependents are the Primary Enrollee's Spouse and unmarried dependent children from birth to age 26
- Children include natural children, stepchildren, grandchildren, foster children, adopted children (including a prospective adoptive child of the adopting parents and/or grandparents from the earlier date of the judicial decree of the adoption or the assumption of custody pending adoption), children placed for adoption and children of a partner as recognized by the Contractholder and children for which the employee has been appointed legal guardianship or temporary guardian of more than twelve (12) months duration or for a shorter period if the guardianship is of a dependent minor and granted by testamentary appointment. The dependents of Primary Enrollees are eligible to enroll on the same date that the employee, of whom they are a Dependent, becomes a Primary Enrollee. Later-acquired dependents become eligible as soon as they acquire dependent status. A minor for whom guardianship has been granted by court or testamentary appointment is eligible from the date of appointment.
- An overage unmarried dependent child may be eligible if:
 - (1) he/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/she is chiefly dependent on the eligible employee for support; and
 - (3) proof of dependent child's disability is provided within 31 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the eligible employee for support because of a physically or mentally disabling injury, illness or condition that began before he or she reached the limiting age.

A newly born or newly adopted dependent child or grandchild is eligible from the moment of birth or date of adoption of the child or grandchild. A minor for whom guardianship is granted by court or testamentary appointment is eligible from the date of appointment.

If payment of a specific premium or subscription fee is required to provide coverage for a child or grandchild or minor for whom guardianship is granted by court or testamentary appointment, Delta Dental may require notification of a birth, adoption, or appointment and payment of the required premium or fee within 31 days after the date of birth, date of adoption, or date of court or testamentary appointment in order to continue coverage beyond the 31-day period.

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

Enrollment Requirements

If the Contractholder is paying all premiums for you and your dependents, everyone is automatically enrolled.

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

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

Loss of Eligibility

Your coverage ends when you are no longer an Eligible Employee of the Contractholder or when the Contract ends. Your Spouse loses coverage when your coverage ends or when dependent status is lost. Your dependent children lose coverage when your coverage ends or when dependent status is lost.

Continuation of Benefits

We will not pay for any services/treatment received after your coverage ends. However, we will extend benefits for at least 90 days after the date on which your coverage ends or until the services are complete if the treatment:

- (1) begins before the date coverage terminates; and
- (2) requires two or more visits on separate days to a dentist's office.

In the case of orthodontic procedures, notwithstanding any other limitation on orthodontic benefits, we will extend benefits:

- (1) for 60 days if the orthodontist has agreed to or is receiving monthly payments; or
- (2) for 60 days or until the end of the quarter in progress, whichever is longer, if the orthodontist has agreed to or is receiving quarterly payments.

Strike, Lay-off and Leave of Absence

You and your dependents will not be covered for any dental services received while you are 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*. As such, coverage and premium payment will cease.

Benefits for you and your Dependent Enrollees will resume as follows:

- if coverage is reactivated in the same Contract Year, Deductibles and maximums will resume as if you were never gone; or
- if coverage is reactivated in a different Contract Year, new Deductibles and maximums will apply.

Coverage will resume provided the Contractholder submits a request to Delta Dental that coverage be reactivated.

*Coverage for you and your dependents is not affected if you take a leave of absence allowed under the Family & Medical Leave Act of 1993 or other applicable state or federal law. If you are currently paying any part of

your premium, you may choose to continue coverage. If you do not continue coverage during the leave, you can resume that coverage on your return to active work as if no interruption occurred.

Important: The Family & Medical Leave Act of 1993 does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

If you are rehired within the same Contract Year, Deductibles and maximums will resume as if you were never gone.

Continued Coverage under USERRA

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you are covered by the Contract 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:

- 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.

CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED

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

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

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under the Contract. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

Enrollee Coinsurance

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

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider providing the service (see section titled "Selecting Your Provider"). Providers are required to collect Enrollee Coinsurance for covered services. Your group has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the Contractholder and Enrollees. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, we will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that are discounted, waived or rebated.

It is to your advantage to select PPO Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the sections titled “Selecting Your Provider” and “How Claims Are Paid” for more information.

Deductible

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

Maximum Amount

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

Pre-Treatment Estimate

Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under the Contract for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before you agree to receive any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of the Contract when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days unless other services are received after the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:

- the date the Contract terminates;
- the date Benefits under the Contract are amended if the services in the Pre-Treatment Estimate are part of the amendment;
- the date your coverage ends; or
- the date the Provider’s agreement with Delta Dental ends.

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

Coordination of Benefits

We coordinate the Benefits under the Contract with an Enrollee’s benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other policies. If this plan is the “primary” plan, we will not reduce Benefits. If this plan is the “secondary” plan, we may reduce Benefits otherwise payable under the Contract. Delta Dental will calculate the Benefits it would have paid on the claim in the absence of other coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the other plan. Delta Dental may reduce its payment by the amount so that, when combined with the amount paid by the other plan, the total benefits paid or provided by all plans do not exceed 100 percent of total allowable expenses. In addition, Delta Dental shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other coverage. An allowable expense is a dental care expense, including Deductibles, coinsurance and copayments, which is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. A plan includes: group insurance contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law. A plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage; school accident type coverage; benefits for non-medical components of long term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

- How do we determine which plan is the “primary” program?
 - (1) The plan covering you as an employee is primary over a plan covering you as a dependent.
 - (2) The plan covering you as an employee is primary over a plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - a) secondary to the plan covering the insured person as a dependent and
 - b) primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.
 - (3) Except as stated below, when this plan and another plan cover the same child as a dependent of different persons, called parents:
 - a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but
 - b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
 - c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
 - (4) Unless there is a court decree stating otherwise, in the case of a dependent child of legally separated or divorced parents, or parents who are not living together, whether or not they have ever been married, the order of benefits for the Enrollee is as follows:
 - a) The plan covering the custodial parent;
 - b) The plan covering the custodial parent’s spouse;
 - c) The plan covering the non-custodial parent; and then
 - d) The plan covering the non-custodial parent’s spouse.

If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.
 - (5) If a court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, the provisions of paragraph (3) above shall determine the order of benefits.
 - (6) If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in (3) a) through (3) c).
 - (7) The Benefits of a plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
 - (8) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:
 - a) First, the Benefits of a plan covering the insured person as an employee or Primary Enrollee (or as that insured person’s dependent);

b) Second, the Benefits under the continuation coverage.

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

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

SELECTING YOUR PROVIDER

Free Choice of Provider

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

Locating a PPO Provider

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

Choosing a PPO Provider

A PPO Provider potentially allows the greatest reduction in Enrollees' out-of-pocket expenses since this select group of Providers will provide dental Benefits at a charge that has been contractually agreed upon. Payment for covered services performed by a PPO Provider is based on the Maximum Contract Allowance.

Choosing a Premier Provider

A Premier Provider is a Delta Dental Provider who has not agreed to the features of the PPO plan. Payment for covered services performed by a Premier Provider is based on the Maximum Contract Allowance. The amount charged by a Premier Provider may be above that accepted by PPO Providers but no more than the Delta Dental Premier Contracted Fee.

Choosing a Non-Delta Dental Provider

If a Provider is a Non-Delta Dental Provider, the amount charged to Enrollees may be above that accepted by PPO or Premier Providers, and Enrollees will be responsible for balance billed amounts. Payment for covered services performed by a Non-Delta Dental Provider is based on the Maximum Contract Allowance, and the Enrollee may be balance billed up to the Provider's Submitted Fee.

Additional Obligations of PPO and Premier Providers

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

How to Submit a Claim

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

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

Delta Dental of Pennsylvania
P.O. Box 2105
Mechanicsburg, PA 17055-2105

Payment Guidelines

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

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

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

Provider Relationships

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

CLAIMS APPEAL

Delta Dental has installed an extensive grievance procedure sensitive to the rights of Enrollees. Please refer to Delta Dental’s Internal Grievance Procedure attached to this booklet.

GENERAL PROVISIONS

Non-Discrimination

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

Delta Dental of Pennsylvania
P.O. Box 2105
Mechanicsburg, PA 17055-2105

Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider’s care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us at our expense, in or near your community or residence. If an examination is required, it will be performed at our expense. We will in every case hold such information and records confidential.

Notice of Claim Form

We will give you or your Provider, on request, a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

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

Written Notice of Claim/Proof of Loss

We must be given written proof of loss within 12 months after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

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

Time of Payment

Claims payable under the Contract for any loss other than loss for which the Contract provides any periodic payment will be processed no later than 30 days after written proof of loss is received. We will notify you and your Provider of any additional information needed to process the claim within this 30 day period. Claims not processed as stated above are subject to interest on the amount of the claim that remains unpaid 30 days after receipt of the initial clean claim for reimbursement at the monthly rate of:

- 1.5 percent from the 31st day thru the 60th day;
- 2 percent from the 61st day thru the 120th day; and
- 2.5 percent after the 120th day.

To Whom Benefits Are Paid

It is not required that the service be provided by a specific dentist. Payment for services provided by a PPO or Premier Provider will be made directly to the dentist. Any other payments provided by the Contract will be made to you. All Benefits not paid to the Provider will be payable to you, the Primary Enrollee, or Dependent Enrollee, or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his or her parent, guardian, or to any relative by blood or connection by marriage of the individual who is considered by Delta Dental to be equitably entitled to the benefit, up to an amount not exceeding \$5,000.

Misstatements on Application: Effect

In the absence of fraud, all statements made by you or the Contractholder will be deemed representations and not warranties. No such statement will be used in defense to a claim under the Contract, unless it is contained in a written instrument signed by the Enrollee or the Contractholder, a copy of which has been furnished to you or the Contractholder.

A statement made by any Enrollee covered under the Contract relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of two (2) years during the Enrollee's lifetime.

Legal Actions

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

Conformity With Prevailing Laws

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

Misstatement of Age

If the age of the Primary Enrollee or Dependent Enrollee has been misstated, all amounts payable under the Contract shall be such as the Premium paid would have purchased at the correct age.

Delta Dental of Pennsylvania's Internal Grievance Procedure

(1) *Denial of payment based upon lack of coverage of benefit under the Contract or Enrollee's eligibility status i.e. coverage decisions made pursuant to Title 15, Subtitle 10D of the Maryland Insurance Article, that are not considered Adverse Decisions under Title 15, Subtitle 10A of the Maryland Insurance Article.*

If a post-service claim¹ is denied in whole or in part, Delta Dental shall notify the Enrollee, the Enrollee's Representative, and the attending dentist of the denial in writing within thirty (30) days after the claim is filed, unless special circumstances require an extension of time, not exceeding, fifteen (15) days for processing. If there is an extension, the Enrollee, the Enrollee's Representative, and the attending dentist shall be notified of the extension and the reason for the extension within the original thirty (30) day period. If an extension is necessary because either the Enrollee, the Enrollee's Representative, or the attending dentist did not submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information. The Enrollee, the Enrollee's Representative, or the attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specific information. The extension period (fifteen (15) days) – within which a decision must be made by Delta Dental – will begin to run from the date on which the Enrollee's response is received by Delta Dental (without regard to whether all of the requested information is provided) or, if earlier, the due date established by Delta Dental for furnishing the requested information (at least forty-five (45) days).

The notice of denial shall explain the specific reason or reasons why the claim was denied in whole or in part, including a specific reference to the pertinent Contract provisions on which the denial is based, a description of any additional material or information necessary for the Enrollee to perfect the claim and an explanation as to why such information is necessary. The notice of denial shall also contain an explanation of Delta Dental's claim review and appeal process and the time limits applicable to such process, including a statement of the Enrollee's right to bring a civil action under ERISA upon completion of Delta Dental's second level of review. The notice shall refer to any internal rule, guideline, and protocol that were relied upon (and that a copy will be provided free of charge upon request). The notice shall also include the following statement:

ATTN. FULLY INSURED MARYLAND ENROLLEES: THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES. You, your Representative, or your Health Care Provider may contact the Health Advocacy Unit of Maryland's Consumer Protection Division at: Office of the Attorney General, 200 Saint Paul Place, 16th Floor, Baltimore, Maryland 21202. The phone number is 877-261-8807 (toll free) or 410-528-1840 and TTY is 1-800-576-6372. The fax number is 410-576-6571 and the email address is consumer@oag.state.md.us. The Health Advocacy Unit can help you, your Representative or your Health Care Provider prepare a Grievance to file under the carrier's internal Grievance procedure. That unit can also attempt to mediate a resolution to your dispute and file a Complaint with the Commissioner. The Health Advocacy Unit is not available to represent or accompany you during any proceeding of the internal Grievance process. Additionally, you, your Representative, or your Health Care Provider may file a Complaint with the Maryland Insurance Administration at: Attn: Consumer Complaint Investigation, Life and Health/Appeals and Grievance, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202, Phone: 1-800-492-6116 or 410-468-2000, TTY: 1-800-735-2258, Fax: 410-468-2270 or 410-468-2260. The Complaint may be filed without having to first file a Grievance with Delta Dental, if: (1) Delta Dental has waived the requirement that its internal Grievance process be exhausted; (2) Delta Dental failed to comply with any of the requirements of the internal Grievance process; or (3) You, your Representative or your Health Care Provider can show a compelling reason to file a Complaint, including that a delay in receiving the Health Care Service could result in loss of life, serious impairment to a bodily function, or serious dysfunction of

¹ Delta Dental does not condition receipt of a benefit, in whole or in part, upon approval of the benefit in advance of obtaining dental care. Additionally, Delta Dental does not conduct concurrent review relating to continued or extended health care services, or additional services for an insured undergoing a course of continued treatment.

a bodily organ or part, or the Enrollee remaining seriously mentally ill with symptoms that cause the Enrollee to be in danger to self or others. **INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN THE GROUP CONTRACT.**

If the Enrollee, the Enrollee's Representative, or the attending dentist wants the denial of benefits reviewed, the Enrollee, the Enrollee's Representative, or the attending dentist must write to Delta Dental within one hundred eighty (180) days of the date on the denial letter. In the letter, the Enrollee, the Enrollee's Representative, or attending dentist should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. The Enrollee, the Enrollee's Representative, or the attending dentist is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination.

The review shall be conducted on behalf of Delta Dental by a person who is neither the individual who made the claim denial that is the subject of the review, nor the subordinate of such individual. If the review is of a claim denial based in whole or in part on a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available to the Enrollee, the Enrollee's Representative, or the attending dentist on request. In making the review, Delta Dental will not afford deference to the initial adverse benefit determination.

If after review, Delta Dental continues to deny the claim, Delta Dental shall notify the Enrollee, the Enrollee's Representative, or the attending dentist in writing of the decision on the request for review within thirty (30) days of the date the request is received. Delta Dental shall send to the Enrollee, the Enrollee's Representative, or attending dentist a notice, which contains the specific reason or reasons for the adverse determination and reference to the specific Contract provisions on which the benefit determination is based. The notice shall state that the Enrollee, the Enrollee's Representative, or attending dentist is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the Enrollee's claim for benefits. The notice shall refer to any internal rule, guideline and protocol that were relied upon (and that a copy will be provided free of charge upon request). The notice shall state that if the claim denial is based on dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, an explanation is available free of charge upon request by either the Enrollee, the Enrollee's Representative, or the attending dentist. The notice shall also state that the Enrollee has a right to bring an action under ERISA upon completion of Delta Dental's second level of review, and shall state: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance agency."

If in the opinion of the Enrollee, the Enrollee's Representative, or attending dentist, the matter warrants further consideration, the Enrollee, the Enrollee's Representative, or the attending dentist should advise Delta Dental in writing as soon as possible. The matter shall then be immediately referred to Delta Dental's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta Dental's Dental Affairs Committee if requested by the Enrollee, the Enrollee's Representative, or the attending dentist. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration, or within sixty (60) working days of the initial request for review described above, whichever is sooner. The notice of decision will state the specific factual bases for the decision. It will also include: the Maryland Insurance Commissioner's address, telephone number, and facsimile number; a statement that the Enrollee, the Enrollee's Representative, or his or her dentist, has a right to file a Complaint with the Maryland Insurance Commissioner within four (4) months after receipt of Delta Dental's appeal decision; a statement that the Health Advocacy Unit is available to assist the Enrollee, the Enrollee's Representative, or the attending dentist in filing a Complaint with the Commissioner; and the address, telephone number, facsimile number and email address of the Health Advocacy Unit. The decision of the Dental Affairs Committee shall be final insofar

as Delta Dental is concerned. Recourse thereafter would be to the Maryland Insurance Commissioner, or to the courts with an ERISA or other civil action.

(2) *Denial of a covered benefit where the service is not dentally necessary, appropriate or efficient, i.e. claim benefit determinations that are considered Adverse Decisions - under Title 15, Subtitle 10A of the Maryland Insurance Article.*

I. Definitions

- A. Adverse Decision shall mean a utilization review determination by a Private Review Agent, a carrier, or a Health Care Provider acting on behalf of a carrier that: (1) a proposed or delivered Health Care Service covered under the Enrollee's contract is or was not medically necessary, appropriate, or efficient; and (2) may result in non-coverage of Health Care Service. An Adverse Decision does not include a decision concerning an Enrollee's status.
- B. Complaint shall mean a protest filed with the Commissioner involving an Adverse Decision or Grievance Decision concerning an Enrollee.
- C. Enrollee shall mean a person entitled to health care benefits under a policy, plan, or certificate issued or delivered in Maryland by Delta Dental. Unless preempted by federal law, Enrollee includes a Medicare recipient. Enrollee does not include a Medicaid recipient.
- D. Enrollee's Representative shall mean a person who has been authorized by the Enrollee to file a Grievance on behalf of the Enrollee.
- E. Filing Date shall mean the earlier of five (5) days after the date of mailing or the date of receipt.
- F. Grievance shall mean a protest filed by an Enrollee, an Enrollee's Representative, or a Health Care Provider on behalf of an Enrollee with Delta Dental through Delta Dental's internal Grievance process regarding an Adverse Decision concerning the Enrollee.
- G. Grievance Decision shall mean a final determination by Delta Dental that arises from a Grievance filed with Delta Dental under its internal Grievance process regarding an Adverse Decision concerning an Enrollee.
- H. Health Advocacy Unit shall mean the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of Attorney General established under Commercial Law Article, Title 13, Subtitle 4A, Annotated Code of Maryland.
- I. Health Care Provider shall mean: (1) an individual who is licensed under the Health Occupations Article to provide Health Care Services in the ordinary course of business or practice of a profession and is a treating provider of the Enrollee; or (2) a hospital, as defined in section 19301 of the Health-General Article.
- J. Health Care Service shall mean a health or medical care procedure or service rendered by a Health Care Provider including: (1) testing, diagnosis, or treatment of a human disease or dysfunction; (2) dispensing drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction; and (3) any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well-being of an individual.
- K. Private Review Agent shall mean: (1) a non-hospital affiliated person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of a Maryland business entity or a third party that provides or administers hospital benefits to citizens of Maryland including a health maintenance organization, a health insurer, nonprofit health service plan, health insurance service organization, or preferred provider organization authorized to offer health insurance policies or contracts in Maryland; or (2) any person or entity including a hospital-affiliated person performing utilization review for the purpose of making claims or payment decisions on behalf of the employer's or labor union's health insurance plan under an employee assistance program for employees other than the employees employed by the hospital; or employed by a business wholly owned by the hospital.

II. Standard Claims Procedure

- A. Processing of Claims: Delta Dental shall process all claims as expeditiously as possible. Within 30 days after receipt of a claim, Delta Dental shall either:
1. Pay the entire claim or any undisputed portion of the claim;
 2. Send a notice of receipt and status of the claim in accordance with sections II(B) and II(C) below that states that Delta Dental denies all or part of the claim and the reason for the denial; or
 3. If within three (3) calendar days after receipt of the initial request for Health Care Services, Delta Dental does not have sufficient information to make a determination, Delta Dental shall inform the attending dentist of the information necessary to make the determination.
 4. Send a notice of receipt and status of the claim that states that Delta Dental will require an additional fifteen (15) days² to process the claim due to the failure of the Enrollee to submit the information necessary to decide the claim. The notice will state either that:
 - a. The legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or
 - b. That the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.
- The Enrollee, the Enrollee's Representative, or the attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specific information.
- B. Rendering of an Adverse Decision: When Delta Dental renders an Adverse Decision³ on all or part of a post-service claim⁴, Delta Dental shall:
1. Provide oral communication of the decision to the Enrollee, the Enrollee's Representative, or the attending dentist;
 2. Document the Adverse Decision in writing after Delta Dental has provided oral communication of the decision to the Enrollee, the Enrollee's Representative, or the attending dentist.

²The extension period (fifteen (15) days) – within which a decision must be made by Delta Dental – will begin to run from the date on which the Enrollee's response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least forty-five (45) days).

³All Adverse Decisions i.e., decisions which are based upon whether a service was medically necessary, appropriate, or efficient, shall be made by a licensed dentist, or a panel of other appropriate Health Care Service reviewers with at least one licensed dentist on the panel.

⁴Delta Dental does not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Additionally, Delta Dental does not conduct concurrent review relating to continued or extended Health Care Services, or additional services for an insured undergoing a course of continued treatment.

C. Notice of Adverse Decision: Within 5 working days after the Adverse Decision has been made, Delta Dental shall send a written notice to the Enrollee, the Enrollee's Representative, and the attending dentist that:

1. States in detail in clear, understandable language the specific factual bases for the carrier's decision;
2. References the specific criteria and standards, including interpretive guidelines on which the decision was based;
3. States the name, business address, and business telephone number of the designated Delta Dental employee or representative who is responsible for Delta Dental's internal Grievance process as follows:

Alice Strobel
Manager, Professional Services
Delta Dental
11155 International Drive
Rancho Cordova, CA 95670
Phone: 916-861-2612
Fax: 916-631-6374
Email: astrobel@delta.org

4. Gives written details of Delta Dental's internal Grievance process and procedures as follows:

If you, your Representative, or your attending dentist want the Adverse Decision reviewed, you, your Representative, or your attending dentist must contact Delta Dental, either in writing or by calling Delta Dental's toll-free number, 1-800-932-0783, ***within one hundred eighty (180) days of the date on this notice.*** You, your Representative, or your attending dentist should state why the claim should not have been denied. Also, any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. You, your Representative, or your attending dentist are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered initially.

The review shall be conducted for Delta Dental by a licensed dentist who is neither the licensed dentist who made the claim denial that is the subject of the review, nor the subordinate of such individual. The review shall be conducted by a licensed dentist, or a panel of appropriate Health Care Service reviewers with at least one dentist on the panel who is a licensed dentist. Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such dental consultant. The identity of such dental consultant is available upon request whether or not the advice was relied upon. In making the review, Delta Dental will not afford deference to the initial Adverse Decision.

If after review, Delta Dental continues to deny the claim, Delta Dental shall notify you, your Representative, or your attending dentist in writing of the Grievance Decision within forty-five (45) days of the date the request is received. Delta Dental shall send you, your Representative, or your attending dentist a notice, similar to this notice. If in the opinion of you, your Representative, or your attending dentist, the matter warrants *further* consideration, you may file an action in the courts pursuant to section 502(a) of ERISA. If you are a fully insured Enrollee, you, your Representative, or your attending dentist also have the option to file a Complaint with the Maryland Insurance Administration within four

(4) months after receipt of Delta Dental's Grievance Decision. A Complaint may be filed without first filing a Grievance if: (1) Delta Dental has waived the requirement that its internal Grievance process be exhausted; (2) Delta Dental failed to comply with any of the requirements of the internal Grievance process; or (3) You, your Representative, or your attending dentist can demonstrate a compelling reason to do so as determined by the Maryland Insurance Administration.

5. Includes the following information:

- a. That, if the Enrollee is fully insured, the Enrollee, the Enrollee's Representative, or attending dentist has a right to file a Complaint with the Commissioner within four (4) months after receipt of Delta Dental's Grievance Decision;
- b. The following disclosure in at least 12-point typeface, with the first sentence in bold capital typeface:

ATTN. FULLY INSURED MARYLAND ENROLLEES: THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES. You, your Representative, or your Health Care Provider may contact the Health Advocacy Unit of Maryland's Consumer Protection Division at: Office of the Attorney General, 200 St. Paul Place, 16th Floor, Baltimore, Maryland 21202. The phone number is 877-261-8807 (toll-free) or 410-528-1840 and TTY is 1-800-576-6372. The fax number is 410-576-6571 and the email address is consumer@oag.state.md.us. The Health Advocacy Unit can help you, your Representative, or your Health Care Provider prepare a Grievance to file under Delta Dental's internal Grievance procedure. That unit can also attempt to mediate a resolution to your dispute and file a Complaint with the Commissioner. The Health Advocacy Unit is not available to represent or accompany you during any proceeding of the internal Grievance process. Additionally, you, your Representative, or your Health Care Provider may file a Complaint with the Maryland Insurance Administration at: Attn: Consumer Complaint Investigation, Life and Health/Appeals and Grievance, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202, Phone: 1-800-492-6116 or 410-468-2000, TTY: 1-800-735-2258, Fax: 410-468-2270 or 410-468-2260. The Complaint may be filed without having to first file a Grievance with Delta Dental, if: (1) Delta Dental has waived the requirement that its internal Grievance process be exhausted; (2) Delta Dental failed to comply with any of the requirements of the internal Grievance process; or (3) You, your Representative, or your Health Care Provider can show a compelling reason to file a Complaint, including that a delay in receiving the Health Care Service could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ or part, or the Enrollee remaining seriously mentally ill with symptoms that cause the Enrollee to be in danger to self or others. **INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN YOUR GROUP CONTRACT.**

III. Internal Grievance Procedure

- A. Informal Inquiry Option: If a claim is denied in whole or in part, an Enrollee, an Enrollee's Representative, or his or her attending dentist may make an informal inquiry regarding general program, eligibility questions and Adverse Decisions by contacting Delta Dental via its toll-free number at 1-800-932-0783. Every caller has access to a supervisor if dissatisfied with the response.
- B. Non-emergency Appeals of Adverse Decisions: In lieu of making an informal inquiry, an Enrollee, an Enrollee's Representative, or his or her attending dentist may choose to appeal the Adverse Decision. The Enrollee, Enrollee's Representative or Health Care Provider may do so within one hundred eighty (180) days, either by writing to Delta Dental or by calling Delta Dental at its toll-free number. Written acknowledgement of the filing of the appeal to the appealing party will be provided to the Enrollee, the Enrollee's Representative, or the attending dentist within five (5) days of the filing of the appeal. The letter or oral request for appeal should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. The Enrollee, the Enrollee's Representative, or the attending dentist are entitled to

receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim.

- C. Notification of Information Necessary to Conduct the Internal Grievance Process: If Delta Dental requires information necessary to conduct the internal Grievance process, Delta Dental shall notify the Enrollee, the Enrollee's Representative, or the attending dentist, in writing within five (5) working days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, Delta Dental shall request the missing information, in writing, within five (5) working days of receipt of the partial information. Delta Dental will assist the Enrollee, the Enrollee's Representative, or the Health Care Provider in gathering the necessary information without further delay.
 - D. The Review: The review shall be conducted for Delta Dental by a dental consultant who is neither the dental consultant who made the claim denial that is the subject of the review, nor the subordinate of such individual. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination. The review shall be conducted by a licensed dentist, or a panel of appropriate Health Care Service reviewers with at least one dentist on the panel who is a licensed dentist. Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available on request. In making the review, Delta Dental will not afford deference to the initial Adverse Decision. A clinical examination at Delta Dental's cost may be implemented, along with discussion among dentist consultants. At this point, the Enrollee may also request a hearing.
 - E. Grievance Decision: Delta Dental shall make a Grievance Decision within forty-five (45) days of the date the Grievance is filed. However, Delta Dental may extend this 45-day period with the written consent of the Enrollee, the Enrollee's Representative, or the attending dentist who filed the Grievance on behalf of the Enrollee, for a period of no longer than thirty (30) working days. Delta Dental shall document the Grievance Decision in writing after Delta Dental has provided oral communication of the decision to the Enrollee, the Enrollee's Representative, or the attending dentist. Within five (5) days after the Grievance Decision has been made, Delta Dental shall send a written notice to the Enrollee, the Enrollee's Representative, or the attending dentist in accordance with Section IV below. The Grievance Decision shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the courts with an ERISA or other civil action, or to the Maryland Insurance Administration.
 - F. Complaints: An Enrollee, an Enrollee's Representative, or the attending dentist has a right to file a Complaint with the Commissioner within four (4) months after receipt of Delta Dental's Grievance Decision. When filing a Complaint with the Commissioner, the Enrollee or the Enrollee's Representative will be required to authorize the release of any medical records of the Enrollee that may be required to be reviewed for the purpose of reaching a decision on the Complaint.
- IV. Distribution of Information to Enrollees/Enrollees' Representatives/Attending Dentists Upon Entry of Grievance Decision. The paragraphs below outline the contents of the Notification of Grievance Decision.
- A. Content and Notification of Grievance Decision. If after the claim is reviewed, Delta Dental continues to deny the claim, Delta Dental shall send the Enrollee, the Enrollee's Representative, or the attending dentist a notice, which contains:
 1. A clear statement in understandable language containing the specific factual basis for Delta Dental's decision;
 2. A clear statement that the notice constitutes Delta Dental's final Grievance Decision;

3. Reference to the specific criteria and standards, including interpretive guidelines, on which the decision was based (without using only generalized terms such as “experimental procedure not covered”, “cosmetic procedure not covered”, “service included under another procedure”, or “not medically necessary”);
4. The name, business address, and business telephone number of the designated employee or Delta Dental representative who has responsibility for Delta Dental’s internal Grievance process as follows:

Alice Strobel
Manager, Professional Services
Delta Dental
11155 International Drive
Rancho Cordova, CA 95670
Phone: 916-861-2612
Fax: 916-631-6374
Email: astrobel@delta.org

5. A statement that a fully insured Enrollee, Enrollee’s Representative, or Health Care Provider who has filed the Grievance on behalf of a fully insured Enrollee, has a right to file a Complaint with the Commissioner within four (4) months after receipt of Delta Dental’s Grievance Decision;
6. The Commissioner’s address, telephone number and facsimile number as follows:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeals and Grievance
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 1-800-492-6116 or 410-468-2000
TTY: 1-800-735-2258
Fax: 410-468-2270 or 410-468-2260

7. A statement that the Health Advocacy Unit is available to assist the Enrollee or the Enrollee’s representative in both mediating and filing a Grievance under Delta Dental’s internal Grievance process and filing a Complaint with the Commissioner.
8. The address, telephone number, facsimile number, and email address of the Health Advocacy Unit of Maryland’s Consumer Protection Division as follows:

Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840
Toll Free: 877-261-8807
TTY: 1-800-576-6372
Fax: 410-576-6571
Email: consumer@oag.state.md.us

Attachment A
Deductibles, Maximums and Contract Benefit Levels

Contractholder: The Johns Hopkins University- Student Plan

Group Number: 19397

Effective Date: August 15, 2018

Deductibles & Maximums	
Annual Deductible	\$50 per Enrollee each Contract Year \$150 per family each Contract Year
Deductibles waived for	Diagnostic & Preventive Services
Annual Maximum	\$1,500 per Enrollee per Contract Year

Contract Benefit Levels		
Dental Service Category	Delta Dental PPO Provider [†]	Delta Dental Premier and Non-Delta Dental Providers [†]
The Contract Benefit Level for the services shown below are shown on the Table of Allowances (Attachment A-1).		
Diagnostic and Preventive Services	See attached schedule	See attached schedule
Basic Services	See attached schedule	See attached schedule
Major Services	See attached schedule	See attached schedule

[†] Reimbursement is based on PPO Contracted Fees for PPO Providers, Premier Contracted Fees for Premier Providers and Program Allowance for Non-Delta Dental Providers.

**ATTACHMENT A-1
TABLE OF ALLOWANCES**

The amounts in the Allowance column are what Delta Dental will pay for covered services. Enrollees are responsible for paying the remainder of the Accepted Fee, the amount the attending Provider agrees to accept as payment in full for services rendered.

Please note the following:

- *The procedures described and allowances indicated on this table are subject to the terms of the Contract and Delta Dental processing policies and may be limited or excluded.*
- *The below codes and nomenclature are copyright of the American Dental Association. This table represents codes and nomenclature excerpted from the version of Current Dental Terminology (CDT) in effect at the date of this printing. Delta Dental's administration of benefits, limitations and exclusions under this plan at all times will be based on the then current version of CDT whether or not a revised table is provided.*

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D0120	Periodic oral evaluation - established patient	\$22.00
D0140	Limited oral evaluation - problem focused	\$19.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	\$22.00
D0150	Comprehensive oral evaluation - new or established patient	\$28.00
D0160	Detailed and extensive oral evaluation - problem focused, by report	\$28.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	\$19.00
D0180	Comprehensive periodontal evaluation - new or established patient	\$28.00
D0190	Screening of a patient	\$15.00
D0191	Assessment of a patient	\$15.00
D0210	Intraoral - complete series of radiographic images	\$75.00
D0220	Intraoral - periapical first radiographic image	\$20.00
D0230	Intraoral - periapical each additional radiographic image	\$7.00
D0240	Intraoral - occlusal radiographic image	\$19.00
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	\$30.00
D0270	Bitewing - single radiographic image	\$20.00
D0272	Bitewings - two radiographic images	\$30.00
D0273	Bitewings - three radiographic images	\$36.00
D0274	Bitewings - four radiographic images	\$41.00
D0277	Vertical bitewings - 7 to 8 radiographic images	\$75.00
D0330	Panoramic radiographic image	\$63.00
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	\$43.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	\$29.00
D0470	Diagnostic casts	\$62.00
D0472	Accession of tissue, gross examination, preparation and transmission of written report	\$75.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	\$75.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	\$75.00
D0475	Decalcification procedure	B/R*
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	B/R*
D0502	Other oral pathology procedures, by report	B/R*
D0601	Caries risk assessment and documentation, with a finding of low risk	\$4.00
D0602	Caries risk assessment and documentation, with a finding of moderate risk	\$4.00
D0603	Caries risk assessment and documentation, with a finding of high risk	\$4.00
D1110	Prophylaxis - adult	\$65.00
D1120	Prophylaxis - child	\$53.00
D1206	Topical application of fluoride varnish	\$23.00
D1208	Topical application of fluoride – excluding varnish	\$23.00
D1351	Sealant - per tooth	\$27.00
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	\$27.00
D1510	Space maintainer - fixed - unilateral	\$202.00
D1515	Space maintainer - fixed - bilateral	\$278.00
D1520	Space maintainer - removable - unilateral	\$237.00
D1525	Space maintainer - removable - bilateral	\$284.00
D1550	Re-cement or re-bond space maintainer	\$77.00
D1555	Removal of fixed space maintainer	\$77.00
D1575	Distal shoe space maintainer - fixed - unilateral	\$202.00
D2140	Amalgam - one surface, primary or permanent	\$54.00
D2150	Amalgam - two surfaces, primary or permanent	\$65.00
D2160	Amalgam - three surfaces, primary or permanent	\$81.00
D2161	Amalgam - four or more surfaces, primary or permanent	\$88.00
D2330	Resin-based composite - one surface, anterior	\$70.00
D2331	Resin-based composite - two surfaces, anterior	\$70.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D2332	Resin-based composite - three surfaces, anterior	\$77.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	\$95.00
D2390	Resin-based composite crown, anterior	\$164.00
D2391	Resin-based composite - one surface, posterior	\$68.00
D2392	Resin-based composite - two surfaces, posterior	\$95.00
D2393	Resin-based composite - three surfaces, posterior	\$114.00
D2394	Resin-based composite - four or more surfaces, posterior	\$125.00
D2510	Inlay - metallic - one surface	\$110.00
D2520	Inlay - metallic - two surfaces	\$212.00
D2530	Inlay - metallic - three or more surfaces	\$239.00
D2542	Onlay - metallic - two surfaces	\$290.00
D2543	Onlay - metallic - three surfaces	\$290.00
D2544	Onlay - metallic - four or more surfaces	\$290.00
D2610	Inlay - porcelain/ceramic - one surface	\$121.00
D2620	Inlay - porcelain/ceramic - two surfaces	\$234.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	\$263.00
D2642	Onlay - porcelain/ceramic - two surfaces	\$319.00
D2643	Onlay - porcelain/ceramic - three surfaces	\$319.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	\$319.00
D2650	Inlay - resin-based composite - one surface	B/R*
D2651	Inlay - resin-based composite - two surfaces	B/R*
D2652	Inlay - resin-based composite - three or more surfaces	B/R*
D2662	Onlay - resin-based composite - two surfaces	B/R*
D2663	Onlay - resin-based composite - three surfaces	B/R*
D2664	Onlay - resin-based composite - four or more surfaces	B/R*
D2710	Crown - resin-based composite (indirect)	\$108.00
D2712	Crown – ¾ resin-based composite (indirect)	\$108.00
D2720	Crown - resin with high noble metal	\$269.00
D2721	Crown - resin with predominantly base metal	\$260.00
D2722	Crown - resin with noble metal	\$267.00
D2740	Crown – porcelain/ceramic substrate	\$260.00
D2750	Crown - porcelain fused to high noble metal	\$276.00
D2751	Crown - porcelain fused to predominantly base metal	\$268.00
D2752	Crown - porcelain fused to noble metal	\$274.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D2780	Crown - 3/4 cast high noble metal	\$251.00
D2781	Crown - 3/4 cast predominantly base metal	\$251.00
D2782	Crown - 3/4 cast noble metal	\$251.00
D2783	Crown – ¾ porcelain/ceramic	\$251.00
D2790	Crown - full cast high noble metal	\$276.00
D2791	Crown - full cast predominantly base metal	\$268.00
D2792	Crown - full cast noble metal	\$274.00
D2794	Crown - titanium	\$301.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$46.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$46.00
D2920	Re-cement or re-bond crown	\$45.00
D2921	Reattachment of tooth fragment, incisal edge or cusp	\$74.00
D2929	Prefabricated porcelain/ceramic crown – primary tooth	\$146.00
D2930	Prefabricated stainless steel crown - primary tooth	\$94.00
D2931	Prefabricated stainless steel crown - permanent tooth	\$103.00
D2932	Prefabricated resin crown	\$101.00
D2933	Prefabricated stainless steel crown with resin window	\$146.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	\$146.00
D2940	Protective restoration	\$32.00
D2941	Interim therapeutic restoration – primary dentition	\$32.00
D2950	Core buildup, including any pins when required	\$78.00
D2951	Pin retention - per tooth, in addition to restoration	\$27.00
D2952	Post and core in addition to crown, indirectly fabricated	\$138.00
D2954	Prefabricated post and core in addition to crown	\$109.00
D2955	Post removal	B/R*
D2957	Each additional prefabricated post - same tooth	\$87.00
D2960	Labial veneer (resin laminate) - chairside	\$163.00
D2961	Labial veneer (resin laminate) - laboratory	\$272.00
D2962	Labial veneer (porcelain laminate) - laboratory	\$402.00
D2971	Additional procedures to construct new crown under existing partial denture framework	\$55.00
D2980	Crown repair necessitated by restorative material failure	B/R*
D2981	Inlay repair necessitated by restorative material failure	B/R*
D2982	Onlay repair necessitated by restorative material failure	B/R*

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$54.00
D3221	Pulpal debridement, primary and permanent teeth	\$45.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$54.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$54.00
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	\$310.00
D3320	Endodontic therapy, premolar bicuspid tooth (excluding final restorations)	\$373.00
D3330	Endodontic therapy, molar tooth (excluding final restorations)	\$498.00
D3331	Treatment of root canal obstruction; non-surgical access	\$125.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$119.00
D3333	Internal root repair of perforation defects	\$65.00
D3346	Retreatment of previous root canal therapy - anterior	\$315.00
D3347	Retreatment of previous root canal therapy – bicuspid premolar	\$379.00
D3348	Retreatment of previous root canal therapy - molar	\$506.00
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	\$65.00
D3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	\$65.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	\$471.00
D3410	Apicoectomy – anterior	\$222.00
D3421	Apicoectomy – bicuspid premolar (first root)	\$246.00
D3425	Apicoectomy – molar (first root)	\$256.00
D3426	Apicoectomy – (each additional root)	\$83.00
D3427	Periradicular surgery without apicoectomy	\$78.00
D3430	Retrograde filling - per root	\$78.00
D3450	Root amputation - per root	\$166.00
D3920	Hemisection (including any root removal), not including root canal therapy	\$128.00
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$189.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$113.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	\$113.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$210.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$126.00
D4245	Apically positioned flap	\$210.00
D4249	Clinical crown lengthening – hard tissue	\$194.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	\$321.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	\$194.00
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	\$130.00
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	\$130.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration	\$261.00
D4266	Guided tissue regeneration - resorbable barrier, per site	\$146.00
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	\$183.00
D4268	Surgical revision procedure, per tooth	B/R*
D4270	Pedicle soft tissue graft procedure	\$272.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	\$206.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	\$246.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	\$501.00
D4276	Combined connective tissue and double pedicle graft, per tooth	\$204.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	\$185.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	\$138.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$124.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$301.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	\$92.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	\$55.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	\$65.00
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on subsequent visit.	\$52.00
D4910	Periodontal maintenance	\$72.00
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	B/R*
D5110	Complete denture - maxillary	\$345.00
D5120	Complete denture - mandibular	\$345.00
D5130	Immediate denture, maxillary	\$380.00
D5140	Immediate denture, mandibular	\$380.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$313.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$334.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$418.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$418.00
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	\$376.00
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	\$401.00
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$502.00
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$502.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$313.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$313.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	\$171.00
D5410	Adjust complete denture - maxillary	\$17.00
D5411	Adjust complete denture - mandibular	\$17.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D5421	Adjust partial denture - maxillary	\$18.00
D5422	Adjust partial denture - mandibular	\$18.00
D5511	Repair broken complete denture base, mandibular	\$43.00
D5512	Repair broken complete denture base, maxillary	\$43.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$30.00
D5611	Repair resin partial denture base, mandibular	\$37.00
D5612	Repair resin partial denture base, maxillary	\$37.00
D5621	Repair cast partial framework, mandibular	\$39.00
D5622	Repair cast partial framework, maxillary	\$39.00
D5630	Repair or replace broken clasp – per tooth	\$57.00
D5640	Replace broken teeth - per tooth	\$37.00
D5650	Add tooth to existing partial denture	\$48.00
D5660	Add clasp to existing partial denture – per tooth	\$57.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	B/R*
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	B/R*
D5710	Rebase complete maxillary denture	\$147.00
D5711	Rebase complete mandibular denture	\$140.00
D5720	Rebase maxillary partial denture	\$136.00
D5721	Rebase mandibular partial denture	\$142.00
D5730	Reline complete maxillary denture (chairside)	\$61.00
D5731	Reline complete mandibular denture (chairside)	\$61.00
D5740	Reline maxillary partial denture (chairside)	\$59.00
D5741	Reline mandibular partial denture (chairside)	\$59.00
D5750	Reline complete maxillary denture (laboratory)	\$105.00
D5751	Reline complete mandibular denture (laboratory)	\$105.00
D5760	Reline maxillary partial denture (laboratory)	\$97.00
D5761	Reline mandibular partial denture (laboratory)	\$97.00
D5820	Interim partial denture (maxillary)	\$124.00
D5821	Interim partial denture (mandibular)	\$124.00
D5850	Tissue conditioning, maxillary	\$30.00
D5851	Tissue conditioning, mandibular	\$30.00
D5863	Overdenture – complete maxillary	\$345.00
D5864	Overdenture – partial maxillary	\$418.00
D5865	Overdenture – complete mandibular	\$345.00
D5866	Overdenture – partial mandibular	\$418.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D6010	Surgical placement of implant body: endosteal implant	\$516.00
D6013	Surgical placement of mini implant	\$258.00
D6040	Surgical placement: eosteal implant	\$645.00
D6050	Surgical placement: transosteal implant	\$626.00
D6055	Connecting bar – implant supported or abutment supported	\$575.00
D6056	Prefabricated abutment – includes modification and placement	\$180.00
D6057	Custom fabricated abutment – includes placement	\$226.00
D6058	Abutment supported porcelain/ceramic crown	\$365.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	\$332.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	\$321.00
D6061	Abutment supported porcelain fused to metal crown (noble metal)	\$328.00
D6062	Abutment supported cast metal crown (high noble metal)	\$332.00
D6063	Abutment supported cast metal crown (predominantly base metal)	\$321.00
D6064	Abutment supported cast metal crown (noble metal)	\$328.00
D6065	Implant supported porcelain/ceramic crown	\$413.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	\$396.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	\$394.00
D6068	Abutment supported retainer for porcelain/ceramic FPD	\$438.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	\$452.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	\$271.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	\$380.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	\$361.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	\$355.00
D6074	Abutment supported retainer for cast metal FPD (noble metal)	\$360.00
D6075	Implant supported retainer for ceramic FPD	\$365.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	\$554.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	\$381.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	\$55.00
D6090	Repair implant supported prosthesis, by report	B/R*
D6092	Re-cement or re-bond implant/abutment supported crown	\$22.00
D6094	Abutment supported crown - (titanium)	\$361.00
D6095	Repair implant abutment, by report	B/R*
D6100	Implant removal, by report	B/R*
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	\$63.00
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	\$97.00
D6110	Implant /abutment supported removable denture for edentulous arch – maxillary	\$664.00
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular	\$664.00
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary	\$387.00
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular	\$387.00
D6114	Implant /abutment supported fixed denture for edentulous arch – maxillary	\$594.00
D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular	\$594.00
D6116	Implant /abutment supported fixed denture for partially edentulous arch – maxillary	\$516.00
D6117	Implant /abutment supported fixed denture for partially edentulous arch – mandibular	\$516.00
D6194	Abutment supported retainer crown for FPD (titanium)	\$361.00
D6205	Pontic - indirect resin based composite	\$310.00
D6210	Pontic - cast high noble metal	\$229.00
D6211	Pontic - cast predominantly base metal	\$220.00
D6212	Pontic - cast noble metal	\$229.00
D6214	Pontic - titanium	\$301.00
D6240	Pontic - porcelain fused to high noble metal	\$243.00
D6241	Pontic - porcelain fused to predominantly base metal	\$234.00
D6242	Pontic - porcelain fused to noble metal	\$239.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D6245	Pontic - porcelain/ceramic	\$304.00
D6250	Pontic - resin with high noble metal	\$243.00
D6251	Pontic - resin with predominantly base metal	\$234.00
D6252	Pontic - resin with noble metal	\$239.00
D6253	Provisional pontic– further treatment or completion of diagnosis necessary prior to final impression	\$73.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis	\$106.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	\$117.00
D6549	Resin retainer –for resin bonded fixed prosthesis	\$106.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	\$224.00
D6601	Retainer inlay - porcelain/ ceramic - three or more surfaces	\$240.00
D6602	Retainer inlay - cast high noble metal, two surfaces	\$204.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	\$218.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	\$204.00
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces	\$218.00
D6606	Retainer inlay – cast noble metal, two surfaces	\$204.00
D6607	Retainer inlay – cast noble metal – three or more surfaces	\$218.00
D6608	Retainer onlay - porcelain/ ceramic, two surfaces	\$298.00
D6609	Retainer onlay porcelain/ ceramic, three or more surfaces	\$298.00
D6610	Retainer onlay - cast high noble metal, two surfaces	\$271.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	\$271.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	\$271.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	\$271.00
D6614	Retainer onlay - cast noble metal, two surfaces	\$271.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	\$271.00
D6624	Retainer Inlay – titanium	\$218.00
D6634	Retainer Onlay - titanium	\$271.00
D6710	Retainer crown - indirect resin based composite	\$310.00
D6720	Retainer crown - resin with high noble metal	\$269.00
D6721	Retainer crown - resin with predominantly base metal	\$260.00
D6722	Retainer crown - resin with noble metal	\$267.00
D6740	Retainer crown - porcelain/ceramic	\$304.00
D6750	Retainer crown - porcelain fused to high noble metal	\$276.00
D6751	Retainer crown - porcelain fused to predominantly base metal	\$267.00
D6752	Retainer crown - porcelain fused to noble metal	\$274.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D6780	Retainer crown - 3/4 cast high noble metal	\$251.00
D6781	Retainer crown - 3/4 cast predominantly base metal	\$251.00
D6782	Retainer crown - 3/4 cast noble metal	\$251.00
D6783	Retianer crown - 3/4 porcelain/ceramic	\$304.00
D6790	Retainer crown - full cast high noble metal	\$276.00
D6791	Retainer crown - full cast predominantly base metal	\$268.00
D6792	Retainer crown - full cast noble metal	\$274.00
D6793	Provisional retainer crown– further treatment or completion of diagnosis necessary prior to final impression	\$73.00
D6794	Retainer crown - titanium	\$301.00
D6930	Re-cement or re-bond fixed partial denture	\$27.00
D6940	Stress breaker	\$43.00
D6980	Fixed partial denture repair necessitated by restorative material failure	B/R*
D7111	Extraction, coronal remnants – primary deciduous tooth	\$30.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$60.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$88.00
D7220	Removal of impacted tooth - soft tissue	\$108.00
D7230	Removal of impacted tooth - partially bony	\$145.00
D7240	Removal of impacted tooth - completely bony	\$215.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$237.00
D7250	Removal of residual tooth roots (cutting procedure)	\$122.00
D7260	Oroantral fistula closure	\$124.00
D7261	Primary closure of a sinus perforation	\$124.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$181.00
D7280	Exposure of an unerupted tooth	\$83.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$70.00
D7283	Placement of device to facilitate eruption of impacted tooth	\$86.00
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	\$74.00
D7286	Incisional biopsy of oral tissue-soft	\$83.00
D7290	Surgical repositioning of teeth	\$88.00
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	\$100.00
D7296	Corticotomy – one to three teeth or tooth spaces, per quadrant	\$210.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D7297	Corticotomy four or more teeth or tooth spaces, per quadrant	\$210.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$86.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$52.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$115.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$69.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	\$113.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	\$144.00
D7410	Excision of benign lesion up to 1.25 cm	\$98.00
D7411	Excision of benign lesion greater than 1.25 cm	\$148.00
D7412	Excision of benign lesion, complicated	B/R*
D7413	Excision of malignant lesion up to 1.25 cm	B/R*
D7414	Excision of malignant lesion greater than 1.25 cm	B/R*
D7415	Excision of malignant lesion, complicated	B/R*
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	B/R*
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	B/R*
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$78.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$138.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$91.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$138.00
D7465	Destruction of lesion(s) by physical or chemical method, by report	B/R*
D7471	Removal of lateral exostosis (maxilla or mandible)	\$166.00
D7472	Removal of torus palatinus	\$166.00
D7473	Removal of torus mandibularis	\$166.00
D7485	Reduction of osseous tuberosity	\$166.00
D7490	Radical resection of maxilla or mandible	B/R*
D7510	Incision and drainage of abscess - intraoral soft tissue	\$52.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$60.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D7520	Incision and drainage of abscess - extraoral soft tissue	\$62.00
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	B/R*
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	\$74.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	\$104.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	\$91.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	\$164.00
D7610	Maxilla - open reduction (teeth immobilized, if present)	\$348.00
D7620	Maxilla - closed reduction (teeth immobilized, if present)	\$297.00
D7630	Mandible - open reduction (teeth immobilized, if present)	\$455.00
D7640	Mandible - closed reduction (teeth immobilized, if present)	\$349.00
D7650	Malar and/or zygomatic arch - open reduction	B/R*
D7660	Malar and/or zygomatic arch - closed reduction	B/R*
D7670	Alveolus - closed reduction, may include stabilization of teeth	\$182.00
D7671	Alveolus - open reduction, may include stabilization of teeth	B/R*
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	B/R*
D7710	Maxilla - open reduction	\$495.00
D7720	Maxilla - closed reduction	\$394.00
D7730	Mandible - open reduction	\$446.00
D7740	Mandible - closed reduction	\$395.00
D7750	Malar and/or zygomatic arch - open reduction	B/R*
D7760	Malar and/or zygomatic arch - closed reduction	B/R*
D7770	Alveolus - open reduction stabilization of teeth	B/R*
D7771	Alveolus, closed reduction stabilization of teeth	B/R*
D7780	Facial bones- complicated reduction with fixation and multiple approaches	B/R*
D7910	Suture of recent small wounds up to 5 cm	B/R*
D7911	Complicated suture - up to 5 cm	B/R*
D7912	Complicated suture - greater than 5 cm	B/R*
D7920	Skin graft (identify defect covered, location and type of graft)	B/R*
D7940	Osteoplasty - for orthognathic deformities	B/R*
D7941	Osteotomy - mandibular rami	B/R*
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	B/R*

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D7944	Osteotomy - segmented or subapical	B/R*
D7945	Osteotomy - body of mandible	B/R*
D7946	LeFort I (maxilla - total)	B/R*
D7947	LeFort I (maxilla - segmented)	B/R*
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion)-without bone graft	B/R*
D7949	LeFort II or LeFort III - with bone graft	B/R*
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	B/R*
D7952	Sinus augmentation via a vertical approach	\$780.00
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	\$88.00
D7963	Frenuloplasty	\$234.00
D7970	Excision of hyperplastic tissue - per arch	\$122.00
D7971	Excision of pericoronal gingiva	\$83.00
D7972	Surgical reduction of fibrous tuberosity	\$83.00
D7979	Non – surgical sialolithotomy	\$98.00
D7980	Surgical sialolithotomy	\$98.00
D7981	Excision of salivary gland, by report	B/R*
D7982	Sialodochoplasty	\$62.00
D7983	Closure of salivary fistula	\$91.00
D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$45.00
D9120	Fixed partial denture sectioning	\$56.00
D9222	Deep sedation/general anesthesia – first 15 minutes	\$40.00
D9223	Deep sedation/general anesthesia- each subsequent 15 minute increment	\$40.00
D9239	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	\$43.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	\$43.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$28.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$34.00
D9440	Office visit - after regularly scheduled hours	\$68.00
D9450	Case presentation, detailed and extensive treatment planning	B/R*
D9610	Therapeutic parenteral drug, single administration	\$28.00

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	ALLOWANCE
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	\$70.00
D9951	Occlusal adjustment - limited	\$42.00

*By Report - Delta Dental will determine the maximum allowance based on a narrative report submitted by the Provider.

Attachment B Services, Limitations and Exclusions

Contractholder: The Johns Hopkins University –Student Plan

Group Number: 19397 **Effective Date:** August 15, 2018

Description of Dental Services

Delta Dental will pay or otherwise discharge the Maximum Contract Allowance for the services shown on the Table of Allowances (Attachment A-1). Below are general descriptions of the dental services covered on the Table of Allowances.

- **Diagnostic and Preventive Services**

- (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
- (2) Preventive: cleaning (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth, which is considered to be a Diagnostic and Preventive Benefit, and periodontal maintenance, which is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
- (3) Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
- (4) Palliative: emergency treatment to relieve pain.

- **Basic Services**

- (1) Oral Surgery: extractions and other surgical procedures (including pre- and post-operative care).
- (2) General Anesthesia or IV Sedation: when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedure.
- (3) Endodontics: treatment of diseases and injuries of the tooth pulp.
- (4) Periodontics: treatment of gums and bones supporting teeth.
- (5) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated crowns for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- (6) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.
- (7) Specialist Consultations: opinion or advice requested by a general dentist.

- **Major Services**

- (1) Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
- (2) Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.

- ***Note on additional Benefits during pregnancy***

When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Contract Year while the Enrollee is covered under the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; or one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Limitations

- (1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

Examples of Optional Services:

- a) a composite restoration instead of an amalgam restoration on posterior teeth;
- b) a crown where a filling would restore the tooth;
- c) an inlay/onlay instead of an amalgam restoration;
- d) porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown);
or
- e) an overdenture instead of denture.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Delta Dental will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

- (2) Exam and cleaning limitations:
- a) Delta Dental will pay for oral examinations (except after-hours exams and exams for observation) and cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth, periodontal maintenance in the presence of inflamed gums or any combination thereof) no more than twice in a Contract Year.
 - b) A full mouth debridement is allowed once in a lifetime when the Enrollee has no history of prophylaxis, scaling and root planing, periodontal surgery or periodontal maintenance procedures within three (3) years. When allowed a full mouth debridement counts toward the maintenance frequency in the year provided.
 - c) Note that periodontal maintenance, Procedure Codes that include periodontal maintenance and full mouth debridement are covered as a Basic Benefit and that routine cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth) are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
 - d) Caries risk assessments are allowed once in 36 months.
- (3) X-ray limitations:
- a) Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
 - b) When a panoramic film is submitted with supplemental film(s), Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
 - c) If a panoramic film is taken in conjunction with an intraoral complete series, Delta Dental considers the panoramic film to be included in the complete series.
 - d) A complete intraoral series and panoramic film are each limited to once every 60 months.
 - e) Bitewing x-rays are limited to two (2) times in a Contract Year when provided to Enrollees under age 18 and one (1) time each Contract Year for Enrollees age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
- (4) Topical application of fluoride solutions is limited to Enrollees to age 19 and no more than twice in a Contract Year.
- (5) Space maintainer limitations:
- a) Space maintainers are limited to the initial appliance and are a Benefit for an Enrollee to age 14. However, a distal shoe space maintainer-fixed-unilateral is limited to children eight (8) and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
 - b) Recementation of space maintainer is limited to once per lifetime.
 - c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.
- (6) Pulp vitality tests are allowed once per day when definitive treatment is not performed.
- (7) Cephalometric x-rays, oral/facial photographic images and diagnostic casts are covered once per lifetime in conjunction with Orthodontic Services only when Orthodontic Services are a covered benefit. If Orthodontic Services are covered, see Limitations as age limits may apply. However, 3D x-rays are not a covered benefit.

- (8) Sealants are limited as follows:
 - a) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without caries (decay) or restorations on the occlusal surface.
 - b) repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement.
- (9) Specialist Consultations, screenings of patients, and assessments of patients are limited to once per lifetime per Provider and count toward the oral exam frequency.
- (10) Delta Dental will not cover replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.
- (11) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- (12) Prefabricated crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16. Replacement restorations within 24 months are included in the fee for the original restoration.
- (13) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
- (14) Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.
- (15) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.
- (16) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
- (17) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.
- (18) Periodontal limitations:
 - a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy. No more than two quadrants of scaling and root planing will be covered on the same date of service.
 - b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same Provider/Provider office.
 - c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants. Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
 - d) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant. If in the same quadrant, scaling and root planing must be performed at least six (6) weeks prior to the periodontal surgery.
 - e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
 - f) When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a Basic Service and are limited to once in a 24-month period.
- (19) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.
- (20) The following Oral Surgery procedure is limited to age 19 (or orthodontic limiting age): transseptal fiberotomy/supra crestal fiberotomy, by report.
- (21) The following Oral Surgery procedures are limited to age 19 (or orthodontic limiting age) provided Orthodontic Services are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.

- (22) Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when Delta Dental determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- (23) Core buildup, including any pins, are covered not more than once in any 60 month period.
- (24) Post and core services are covered not more than once in any 60 month period.
- (25) Crown repairs are covered not more than twice in any 60 month period. Crowns, inlays/onlays and fixed bridges include repairs for 24 months following installation.
- (26) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.
- (27) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than twice in any 60 month period.
- (28) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Delta Dental's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Delta Dental or any other dental care plan.
- (29) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
- (30) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.
- (31) Delta Dental limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
 - a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
 - b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period.
 - c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
 - d) Recementation of fixed partial dentures is limited to once in a lifetime.

Exclusions

Delta Dental does not pay Benefits for:

- (1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- (2) cosmetic surgery or procedures for purely cosmetic reasons.
- (3) maxillofacial prosthetics.
- (4) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.

- (5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
- (6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.
- (7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
- (8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- (9) charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
- (10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- (11) laboratory processed crowns for Enrollees under age 12.
- (12) fixed bridges and removable partials for Enrollees under age 16.
- (13) interim implants and endodontic endosseous implant.
- (14) indirectly fabricated resin-based Inlays/Onlays.
- (15) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- (16) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- (17) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening or tobacco counseling.
- (18) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- (19) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- (20) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.
- (21) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.
- (22) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- (23) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Services section, if applicable.
- (24) services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves and other tissues) except as provided under the TMJ Benefit section, if applicable.
- (25) missed and/or cancelled appointments.
- (26) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

- (27) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- (28) dental case management motivational interviewing and patient education to improve oral health literacy.
- (29) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- (30) extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.
- (31) claims, bills or other demands or requests for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral.

HIPAA Notice of Privacy Practices

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is required by law to inform you of how Delta Dental and its affiliates ("Delta Dental") protect the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as individually identifiable information regarding a patient's health care history, mental or physical condition or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Delta Dental receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We follow the privacy practices described in this notice and federal and state privacy requirements that apply to our administration of your benefits. Delta Dental reserves the right to change our privacy practice effective for all PHI maintained. We will update this notice if there are material changes and redistribute it to you within 60 days of the change to our practices. We will also promptly post a revised notice on our website. A copy may be requested anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Delta Dental program and will be informed on how to obtain a copy at least every three years.

PERMITTED USES AND DISCLOSURES OF YOUR PHI

Uses and disclosures of your PHI for treatment, payment or health care operations

Your explicit authorization is not required to disclose information about yourself for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or plan sponsor to administer your benefits. As permitted by law, we may disclose PHI to third-party affiliates that perform services for Delta Dental to administer your benefits, and who have signed a contract agreeing to protect the confidentiality of your PHI, and have implemented privacy policies and procedures that comply with applicable federal and state law.

Some examples of disclosure and use for treatment, payment or operations include: processing your claims, collecting enrollment information and premiums, reviewing the quality of health

care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Some other examples are:

- Uses and/or disclosures of PHI in facilitating treatment. *For example, Delta Dental may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment. *For example, Delta Dental may use and disclose your PHI to bill you or your plan sponsor.*
- Uses and/or disclosures of PHI for health care operations. *For example, Delta Dental may use and disclose your PHI to review the quality of care provided by our network of providers.*

Other permitted uses and disclosures without an authorization

We are permitted to disclose your PHI upon your request, or to your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with the law, and when otherwise required by law. Delta Dental may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Some other examples include: to notify or assist in notifying a family member, another person, or a personal representative of your condition; to assist in disaster relief efforts; to report victims of abuse, neglect or domestic violence to appropriate authorities; for organ donation purposes; to avert a serious threat to health or safety; for specialized government functions such as military and veterans activities; for workers' compensation purposes; and, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting, provided it does not contain genetic information. Information can also be de-identified or summarized so it cannot be traced to you and, in selected instances, for research purposes with the proper oversight.

Disclosures Delta Dental makes with your authorization

Delta Dental will not use or disclose your PHI without your prior written authorization unless permitted by law. If you grant an authorization, you can later revoke that authorization, in writing, to stop the future use and disclosure. The authorization will be obtained from you by Delta Dental or by a person requesting your PHI from Delta Dental.

YOUR RIGHTS REGARDING PHI

You have the right to request an inspection of and obtain a copy of your PHI.

You may access your PHI by contacting Delta Dental at the address at the bottom of this notice. You must include (1) your name, address, telephone number and identification number, and (2) the PHI you are requesting. Delta Dental may charge a reasonable fee for providing you copies of your PHI. Delta Dental will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or x-rays, is returned by Delta Dental to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Delta Dental does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact Delta Dental as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI.

You have the right to ask that we limit how we use and disclose your PHI, however, you may not restrict our legal or permitted uses and disclosures of PHI. While we will consider your request, we are not legally required to accept those requests that we cannot reasonably implement or comply with during an emergency. If we accept your request, we will put our understanding in writing.

You have the right to correct or update your PHI.

You may request to make an amendment of PHI we maintain about you. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have rights related to the use and disclosure of your PHI for marketing.

Delta Dental agrees to obtain your authorization for the use or disclosure of PHI for marketing when required by law. You have the opportunity to opt-out of marketing that is permitted by law without an authorization. Delta Dental does not use your PHI for fundraising purposes.

You have the right to request or receive confidential communications from us by alternative means or at a different address.

Alternate or confidential communication is available if disclosure of your PHI to the address on file could endanger you. You may be required to provide us with a statement of possible danger,

as well as specify a different address or another method of contact. Please make this request in writing to the address noted at the end of this notice.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons, certain law enforcement purposes or disclosures made as part of a limited data set. Please contact us at the number at the end of this notice if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by email.

A copy of this notice is posted on the Delta Dental website. You may also request an email copy or paper copy of this notice by calling our Customer Service number listed at the bottom of this notice.

You have the right to be notified following a breach of unsecured protected health information.

Delta Dental will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

COMPLAINTS

You may file a complaint with Delta Dental and/or with the U. S. Secretary of Health and Human Services if you believe Delta Dental has violated your privacy rights. Complaints to Delta Dental may be filed by notifying the contact below. We will not retaliate against you for filing a complaint.

CONTACTS

You may contact Delta Dental at 866-530-9675, or you may write to the address listed below for further information about the complaint process or any of the information contained in this notice.

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

This notice is effective on and after January 1, 2017.

Note: Delta Dental's privacy practices reflect applicable federal law as well as known state law and regulations. If applicable state law is more protective of information than the federal privacy laws, Delta Dental protects information in accordance with the state law.

Last Significant Changes to this notice:

- Clarified that Delta Dental does not use your PHI for fundraising purposes. Effective January 1, 2016
- Clarified that Delta Dental's privacy policy reflect federal and state requirements. – effective January 1, 2015
- Updated contact information (mailing address and phone number) – effective July 1, 2013
- Updated Delta Dental's duty to notify affected individuals if a breach of their unsecured PHI occurs – effective July 1, 2013
- Clarified that Delta Dental does not and will not sell your information without your express written authorization – effective July 1, 2013
- Clarified several instances where the law requires individual authorization to use and disclose information (e.g., fundraising and marketing as noted above) – effective July 1, 2013

DELTA DENTAL AND ITS AFFILIATES

Delta Dental of California offers and administers fee-for-service dental programs for groups headquartered in the state of California.

Delta Dental of New York offers and administers fee-for-service programs in New York.

Delta Dental of Pennsylvania and its affiliates offer and administer fee for-service dental programs in Delaware, Maryland, Pennsylvania, West Virginia and the District of Columbia.

Delta Dental of Pennsylvania's affiliates are Delta Dental of Delaware; Delta Dental of the District of Columbia and Delta Dental of West Virginia.

Delta Dental Insurance Company offers and administers fee-for-service dental programs to groups headquartered or located in Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas and Utah and vision programs to groups headquartered in West Virginia.

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

Dentegra Insurance Company.

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 1-800-521-2651 (TTY: 711).

¿Puede leer este documento? Si no, podemos hacer que alguien lo lea por usted. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 1-800-521-2651 (TTY: 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 1-800-521-2651 (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 1-800-521-2651 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 그렇지 않다면, 다른 사람이 대신 읽어드리도록 도와드릴 수 있습니다. 또한 이 문서를 귀하의 모국어로 번역해드릴 수 있습니다. 무료 지원을 요청하시려면, 1-800-521-2651 (TTY: 711)번으로 연락하십시오. (Korean)

Mababasa mo ba ang dokumentong ito? Kung hindi, mayroong makatutulong sa iyo na basahin ito. Maaring makuha mo rin ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-800-521-2651 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, то вы можете попросить кого-нибудь в нашей компании помочь вам прочитать этот документ. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-800-521-2651 (TTY: 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 1-800-521-2651 (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 1-800-521-2651 (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 1-800-521-2651 (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 1-800-521-2651 (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 1-800-521-2651 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche essere in grado di ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-800-521-2651 (TTY: 711). (Italian)

この文書をお読みになれますか？お読みになれない場合には、読むためのお手伝いをさせていただきます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、1-800-521-2651 (TTY: 711) までご連絡ください。 (Japanese)

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 1-800-521-2651 (TTY: 711). (German)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخوایا 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: 1-800-521-2651 (TTY: 711). (Persian Farsi)

קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט, עמעצער דו קען אייך העלפן לייענען. איר קענט מעגליך אויך באקומען דעם דאָזיקן דאָקומענט אין אייער שפראך. פאר אומזיסטע הילף, ביטע קלינגט: 1-800-521-2651 (TTY: 711). (Yiddish)

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'í' yídooltahígíí nihee hóló. Díí naaltsos t'áá Diné bizaad k'ehjí ályaaago áldó' nich'í' ádoolníłgo bííghah. T'áá jíík'e shíká i' doolwoł nínizingo koji' béesh holdíílnih 1-800-521-2651 (TTY: 711). (Navajo)

Non-Discrimination Disclosure

Discrimination is Against the Law

Delta Dental complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Delta Dental does 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. Delta Dental 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. Delta Dental 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 Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
Telephone Number 866-530-9675
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 DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Delta Dental provides free aids and services to people with disabilities to communicate effectively with us, such as:

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

Delta Dental also provides free language services to people whose primary language is not English, such as:

- qualified interpreters
- information written in other languages

If you need these services, contact Delta Dental customer service 866-530-9675.