

DeltaCare[®] USA

Dental Health Care Plan

Evidence of Coverage

The Boeing Company BNA

Provided by:

Dentegra Insurance Company
560 Mission Street, Suite 1300
San Francisco, CA 94105

Administered by:

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

deltadentalins.com

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

The Boeing Company
 BNA - Salaried Retiree
 BNA Hourly Pre - 2004 Retiree

Labor Code	Labor Group
501P	International Union, United Automobile, Aerospace and Agriculture Implement Workers of America, Local 887 - El Toro and Palmdale, California
505P	International Union, United Automobile, Aerospace and Agriculture Implement Workers of America, Local 1519 - All locations
513P	International Union, United Automobile, Aerospace and Agriculture Implement Workers of America, Local 952 - Tulsa, Oklahoma (COBRA only)
514P	International Union, United Automobile, Aerospace and Agriculture Implement Workers of America, Local 1558 - McAlester, Oklahoma (COBRA only)
561P	International Brotherhood of Carpenters & Joiners of America, Local 721 - LA Basin, California (Carpenters)
562P	International Brotherhood of Electrical Workers, AFL-CIO, Local 2295 - LA Basin, California
565P	International Brotherhood of Painters & Allied Trades of America, Local 36 - California (Painters)
567P	Sheet Metal Workers International Association, Local 461 - LA Basin, California (Welders)
568P	International Brotherhood of Teamsters, Local 952 - California (Truck Drivers)
569P	International Brotherhood of Teamsters, Local 986 - Southern California
	Service Based Nonunion Salaried BNA Retirees (retirees only - effective August, 2005)
915	Aerospace retired on or after 01/01/1991
916	Corporate retired on or after 01/02/1991
917	Electronics retired on or after 02/02/1992

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

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

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

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

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

EVIDENCE OF COVERAGE

Introduction

DeltaCare® USA Dental Health Care Plan

This Evidence of Coverage (“EOC”) provides information about Your DeltaCare USA Dental Health Care Plan (“Plan”) provided by Dentegra Insurance Company (“Company”), on behalf of itself and its affiliated companies. To offer these Benefits, the Contractholder has entered into a Group Dental Insurance Contract with Us.

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

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

Identification Card (ID)

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

Contract

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

Contact Us

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

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

Notice

This EOC is a summary of Your dental Plan. This information is not a guarantee of covered Benefits, services or payments.

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

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

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Definitions

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

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

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

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

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

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

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

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

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

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

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

Domestic Partner: An individual who has, together with the Primary Enrollee, affirmed a domestic partnership through an affidavit of domestic partnership filed with the Contractholder.

Effective Date: The date the Contract or coverage begins.

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

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

Grace Period: A period of no less than 30 days after the Premium payment is due under the Contract, in which a payment may be made and during which coverage will continue in effect, subject to the Premium payment by the end of the Grace Period.

Maximum Fee Allowance: The maximum amount that We will allow for each covered service or procedure. DeltaCare USA Dentists contractually agree to charge and accept up to the Maximum Fee Allowance as payment in full for that service or procedure. Non-DeltaCare USA Dentists may charge an additional amount over and above the Maximum Fee Allowance, up to their submitted fee for a covered service.

Network Dentist A Dentist who has agreed to provide services at pre-negotiated rates. Not all Dentists who contract with a Delta Dental plan are "Network Dentists." You should confirm the Dentist's participation in the network on Our website (www.deltadentalins.com/deltacareusa) prior to seeking treatment. Or You may contact Customer Service at 800-422-4234.

Non-Participating Dentist or Non-DeltaCare USA Dentist: A Dentist other than a participating Network Dentist.

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

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

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

Premium: Payment made in consideration of dental coverage under the Contract.

Schedules: Dental services and procedures and applicable limitations and exclusions included under Your Plan and described in:

- *Schedule A, Description of Benefits and Copayments, and*
- *Schedule B, Limitations and Exclusions of Benefits.*

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

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

Spouse: An individual who is a partner of the Primary Enrollee as:

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

Eligibility and Enrollment - When Coverage Begins

Eligibility Requirements

The Contractholder is responsible for establishing eligibility and reporting enrollment to Us. We process enrollment as reported by the Contractholder. You will receive Benefits on Your effective date of coverage, as defined by the Contractholder.

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

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

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

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

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

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

Overage Children

An overage Dependent child may be eligible if:

- The child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that began prior to reaching the limiting age;
- The child is chiefly dependent on the Primary Enrollee for support; and
- Proof of disability is provided within 30 days of request. Proof of disability will not be required more than one (1) time per year following a two year period after the Dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Primary Enrollee's for support because of a physically or mentally disabling injury, illness or condition that began before the Dependent reaches the limiting age.

Enrollment Requirements

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

If You are responsible for Your Premium,

- 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 or Special Enrollment Period.
- If You elect Dependent coverage, You must enroll all of Your Dependent Enrollees for coverage.

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

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

You:

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

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

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

Special Enrollment Periods - Enrollment Changes

After Your Effective Date, You may change Your enrollment during an Open Enrollment Period or during a Special Enrollment Period as a result of a qualifying status change. Qualifying status changes include, but are not limited to, the following events:

- Marital status (Examples include, but are not limited to: marriage, divorce, legal separation, annulment or death);
- Number of Dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- Dependent child ceases to satisfy eligibility requirements;
- Employment status (change in Your or Your Dependent's employment status);
- Residence (You move);
- Court order requiring Dependent coverage;
- Loss of other group coverage;
- Any other current or future election changes permitted by Internal Revenue Code Section 125; or
- Any other changes specified by applicable law or regulation.

Premiums

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

How to Use the DeltaCare USA Plan

Choice of Dentist

We will provide Your Plan with Network Dentists at convenient locations or You may choose a Non-Network Dentist. A list of Network Dentists is provided at deltadentalins.com. To confirm a Dentist's participation in the Network, contact the Customer Service department at 800-422-4234.

Receiving treatment from a Network Dentist usually allows You the greatest reduction in out-of-pocket expenses, since this select group of Dentists will provide dental Benefits at a charge which has been contractually agreed upon between Us and the Network Dentist. Network Dentists will complete the dental claim form and submit it to Us for reimbursement.

Non-Network Dentist

If a Dentist is a Non-Network Dentist, the amount charged to You may be greater than what is accepted by Network Dentists. Non-Network Dentists can bill You the difference between the Dentist's submitted fee and the amount paid by Us. A Non-Network Dentist may require payment of all charges at the time services are received.

Payment for Services - Network Dentist

Payment for covered services performed by a Network Dentist is calculated based on the Maximum Fee Allowance. Network Dentists have agreed to accept the Maximum Fee Allowance as payment in full for covered Benefits, less the Copayment amount.

Payment for Services - Non-Network Dentist

We will pay a Non-Network Dentist 80 percent of the Maximum Fee Allowance for the covered Benefit, less the Copayment amount. If You seek treatment from Non-Network Dentists, You are responsible for the difference, if any, between the amount We pay and the Non-Network Dentist's submitted fee for such treatment.

When You receive treatment from a Non-Network Dentist, Our payment is sent directly to You, unless You have made an assignment of Benefits to the Non-Network Dentist.

Benefits, Limitations and Exclusions

This Plan provides the Benefits and any applicable Copayments, deductibles, annual maximums and waiting periods as shown in the attached Schedules.. Only services, supplies or procedures listed in the Schedules and deemed appropriate by Your Contract. Network

Dentist are covered under this Plan. Network Dentists may provide services directly or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

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

Should We fail to pay a Network Dentist, You will not be liable to that Dentist for any sums owed by Us. For further clarification, see "*Emergency Services*."

Emergency Services

You should contact a Dentist for Emergency Services for covered dental procedures whenever possible. You should call Customer Service at 800-422-4234 for assistance in obtaining urgent care.

Claims for Reimbursement

Claims for covered Emergency Services, or Specialist Services or treatment by a Non-Network Dentist should be submitted for payment within 90 days of receiving treatment. Claims must be received within one (1) year of the treatment date. The address for claims submission is:

Claims Department
P.O. Box 1810
Alpharetta, GA 30023

Coordination of Benefits

If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, Benefits will be coordinated. If this plan is the "primary" plan, We will not reduce Benefits. If this plan is the "secondary" plan, We may reduce Benefits so that the total benefits paid or provided by all plans do not exceed 100% of total allowable expense.

But if this plan is the "secondary" plan, We determine Benefits after those of the primary plan and will pay the lesser of the amount that We would pay in the absence of any other dental benefit coverage

or the Enrollee's total out-of-pocket cost under the primary plan for Benefits covered under Your Plan.

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

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

covering the child will follow the order of Benefit determination rules outlined above.

- The Benefits of a plan covering You as an employee who is neither laid-off nor retired are determined before those of a plan covering You as a laid-off or retired employee. The same holds true if You are a dependent of a Primary Enrollee as a retiree or an employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- If Your coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination.
 - * First, the Benefits of a plan covering the Enrollee as an employee or Primary Enrollee (or the Primary Enrollee's dependent).
 - * Second, the Benefits under the continuation coverage.
 - * If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- If none of the above rules determines the order of Benefits, the Benefits of the plan covering an employee longer are determined before those of the plan covering that insured person for the shorter term. When determination cannot be made in accordance with the rules above, the Benefits of a plan that is a medical plan covering dental as a Benefit will be primary to a standalone dental plan.

Enrollee Complaint Procedure

We will provide notification when any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If You have any complaint regarding eligibility, the denial of dental services or claims, Our policies, procedures or operations, or the quality of dental services performed by a Contract Dentist, You may call Customer Service at 800-422-4234 or a written complaint may be submitted to:

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

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

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

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim), You must file a request for review, referred to as a complaint, with Us within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered during the initial benefit determination. The review will be conducted by a person other than the individual who made the original benefit determination, or the individual's subordinate. Upon request and free of charge, You will be provided with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based, in whole or in part, on a lack of medical (dental) necessity, experimental treatment or a clinical judgment in applying the terms of the Plan, We will consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be made available upon request.

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

We will make a determination, in writing, within 30 days of receipt of a complaint or will provide a written explanation if additional time is required to report on the complaint. A review of the decision will be undertaken if a written request for an appeal of the determination is made within 30 days of the date of the written determination. We will undertake a full and fair review upon request. We may require additional documents in making such a review. A written response will be provided to You within 30 days after receipt of Your appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If Your Plan is subject to ERISA, You may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if You have questions about Your rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The US Department of Labor may be contacted at:

U.S. Department of Labor
Employee Benefits Security Administration

200 Constitution Avenue, N.W.
Washington, D.C. 20210

If You believe You need further review of Your claim, You may contact Your Oklahoma insurance regulatory agency.

Renewal and Termination of Benefits

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

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

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

Cancellation of Enrollment

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

Immediately:

- Upon loss of eligibility as described in this EOC; or
- If You engage in conduct detrimental to safe operations and the delivery of services while receiving services from a Contract Dentist.

Upon 15 days written notice if:

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

Upon 30 days written notice if:

- the Contract is terminated or not renewed;
- You fail to pay Copayments. However, You may be reinstated during the term of the Contract upon payment of all delinquent charges; or

- A satisfactory dentist-patient relationship fails to be established with multiple Contract Dentists. We must show that We have, in good faith, provided You with an opportunity to select an alternative Contract Dentist. If You establish a history of unsatisfactory relationships, We will notify You in writing, at least thirty (30) days in advance, that We consider the dentist-patient relationship to be unsatisfactory. We will also specify the changes that are necessary in order to avoid cancellation and show that You failed to make these changes.

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

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

General Provisions

Compliance with Administrative Simplification, Security and Privacy Regulations

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

Conformity With Prevailing Laws

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

Entire Contract; Changes

The Contract, including this EOC, Schedules and any attachments, is the entire agreement between the parties. No agent has authority to change or waive any of its provisions. Changes are not valid unless approved by one of Our executive officers.

Incontestability

After this Contract has been in force for 3 years from the Effective Date, no statement made by the Contractholder will be used to void this Contract. No statement by an employee or You with respect to Your insurability will be used to reduce or deny a claim or contest the validity of insurance for You after that person's coverage has been in effect 3 years or more during the Your lifetime.

No claims for loss incurred or disability commencing after 3 years from the date of issue of the Contract will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed prior to the Effective Date of this Contract.

Legal Actions

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

Misstatements on Application; Effect

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

Processing Policies

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

Severability

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

Strike, Lay-off and Leave of Absence

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

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

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

Continuation of Coverage under USERRA

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

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

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

Continuation of Coverage under COBRA

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

Non-Discrimination

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

We:

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

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

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

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

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

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

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

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2025 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>YOU PAY</u>
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	\$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - comprehensive series of radiographic images - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted.</i>	No Cost

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - <i>limited to 1 series every 6 months</i>	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted</i>	No Cost
D0396	3D printing of a 3D dental surface scan	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - <i>1 every 12 months</i>	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - <i>1 every 12 months</i>	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 12 months</i>	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 12 months</i>	No Cost

D0701	Panoramic radiographic image - image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i>	\$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis <i>cleaning</i> - adult - 1 D1110, D1120 or D4346 per 6 month period	\$5.00
D1110	<i>Additional prophylaxis cleaning</i> - adult (within the 6 month period)	\$45.00
D1120	Prophylaxis <i>cleaning</i> - child - 1 D1110, D1120 or D4346 per 6 month period	\$5.00
D1120	<i>Additional prophylaxis cleaning</i> - child (within the 6 month period)	\$35.00
D1206	Topical application of fluoride varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i>	No Cost
D1208	Topical application of fluoride - excluding varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i>	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars through age 15</i>	\$15.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - <i>limited to permanent molars through age 15</i>	\$15.00

D1353	Sealant repair - per tooth - <i>limited to permanent molars through age 15</i>	\$15.00
D1354	Application of caries arresting medicament - per tooth - <i>child to age 19; 1 per 6 month period</i>	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	\$70.00
D1516	Space maintainer - fixed - bilateral, maxillary	\$70.00
D1517	Space maintainer - fixed - bilateral, mandibular	\$70.00
D1520	Space maintainer - removable - unilateral - per quadrant	\$80.00
D1526	Space maintainer - removable - bilateral, maxillary .	\$80.00
D1527	Space maintainer - removable - bilateral, mandibular	\$80.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	\$15.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	\$15.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	\$15.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	\$15.00
D1557	Removal of fixed bilateral space maintainer - maxillary	\$15.00
D1558	Removal of fixed bilateral space maintainer - mandibular	\$15.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - <i>child to age 9</i>	\$70.00

D2000-D2999 III. RESTORATIVE

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

- *When there are more than six crowns in the same treatment plan, You may be charged an additional \$100.00 per crown, beyond the 6th unit.*

- *Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.*

D2140	Amalgam - one surface, primary or permanent	\$8.00
D2150	Amalgam - two surfaces, primary or permanent	\$12.00
D2160	Amalgam - three surfaces, primary or permanent ..	\$18.00
D2161	Amalgam - four or more surfaces, primary or permanent	\$22.00
D2330	Resin-based composite - one surface, anterior	\$22.00

D2331	Resin-based composite - two surfaces, anterior	\$26.00
D2332	Resin-based composite - three surfaces, anterior ...	\$30.00
D2335	Resin-based composite - four or more surfaces (anterior)	\$55.00
D2390	Resin-based composite crown, anterior	\$65.00
D2391	Resin-based composite - one surface, posterior	\$65.00
D2392	Resin-based composite - two surfaces, posterior ...	\$75.00
D2393	Resin-based composite - three surfaces, posterior .	\$85.00
D2394	Resin-based composite - four or more surfaces, posterior	\$95.00
D2510	Inlay - metallic - one surface	\$185.00
D2520	Inlay - metallic - two surfaces	\$195.00
D2530	Inlay - metallic - three or more surfaces	\$205.00
D2542	Onlay - metallic - two surfaces	\$200.00
D2543	Onlay - metallic - three surfaces	\$210.00
D2544	Onlay - metallic - four or more surfaces	\$230.00
D2610	Inlay - porcelain/ceramic - one surface	\$310.00
D2620	Inlay - porcelain/ceramic - two surfaces	\$345.00
D2630	Inlay - porcelain/ceramic - three or more surfaces ..	\$365.00
D2642	Onlay - porcelain/ceramic - two surfaces	\$340.00
D2643	Onlay - porcelain/ceramic - three surfaces	\$375.00
D2644	Onlay - porcelain/ceramic - four or more surfaces ..	\$395.00
D2650	Inlay - resin-based composite - one surface	\$210.00
D2651	Inlay - resin-based composite - two surfaces	\$235.00
D2652	Inlay - resin-based composite - three or more surfaces	\$270.00
D2662	Onlay - resin-based composite - two surfaces	\$265.00
D2663	Onlay - resin-based composite - three surfaces	\$290.00
D2664	Onlay - resin-based composite - four or more surfaces	\$335.00
D2710	Crown - resin-based composite (indirect)	\$185.00
D2712	Crown - 3/4 resin-based composite (indirect)	\$185.00
D2720	Crown - resin with high noble metal	\$335.00
D2721	Crown - resin with predominantly base metal	\$235.00
D2722	Crown - resin with noble metal	\$275.00
D2740	Crown - porcelain/ceramic	\$395.00
D2750	Crown - porcelain fused to high noble metal	\$395.00

D2751	Crown - porcelain fused to predominantly base metal	\$295.00
D2752	Crown - porcelain fused to noble metal	\$335.00
D2753	Crown - porcelain fused to titanium and titanium alloys	\$395.00
D2780	Crown - 3/4 cast high noble metal	\$395.00
D2781	Crown - 3/4 cast predominantly base metal	\$295.00
D2782	Crown - 3/4 cast noble metal	\$335.00
D2783	Crown - 3/4 porcelain/ceramic	\$395.00
D2790	Crown - full cast high noble metal	\$395.00
D2791	Crown - full cast predominantly base metal	\$295.00
D2792	Crown - full cast noble metal	\$335.00
D2794	Crown - titanium and titanium alloys	\$395.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$20.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$20.00
D2920	Re-cement or re-bond crown	\$20.00
D2921	Reattachment of tooth fragment, incisal edge or cusp (<i>anterior</i>)	\$55.00
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	\$75.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - <i>anterior</i>	\$75.00
D2930	Prefabricated stainless steel crown - primary tooth	\$75.00
D2931	Prefabricated stainless steel crown - permanent tooth	\$75.00
D2932	Prefabricated resin crown - <i>anterior primary tooth</i> .	\$85.00
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i>	\$75.00
D2940	Placement of interim direct restoration	\$20.00
D2949	Restorative foundation for an indirect restoration ..	\$80.00
D2950	Core buildup, including any pins when required	\$80.00
D2951	Pin retention - per tooth, in addition to restoration .	\$15.00
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i>	\$110.00
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i>	\$80.00

D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	\$95.00
D2956	Removal of an indirect restoration on a natural tooth	No Cost
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	\$70.00
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework.	\$60.00
D2976	Band stabilization - per tooth - <i>limited to once in a lifetime per tooth</i>	\$18.00
D2980	Crown repair necessitated by restorative material failure	\$30.00
D2981	Inlay repair necessitated by restorative material failure	\$30.00
D2982	Onlay repair necessitated by restorative material failure	\$30.00
D2983	Veneer repair necessitated by restorative material failure	\$30.00
D2989	Excavation of a tooth resulting in the determination of non-restorability	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to 1 per 24 months</i>	\$15.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	\$5.00
D3120	Pulp cap - indirect (excluding final restoration)	\$5.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinoceamental junction and application of medicament	\$45.00
D3221	Pulpal debridement, primary and permanent teeth	\$50.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	\$45.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$60.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$60.00
D3310	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration)	\$125.00
D3320	<i>Root canal</i> - endodontic therapy, premolar tooth (excluding final restoration)	\$215.00

D3330	Root canal - endodontic therapy, molar tooth (excluding final restoration)	\$365.00
D3331	Treatment of root canal obstruction; non-surgical access	\$80.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$80.00
D3333	Internal root repair of perforation defects	\$80.00
D3346	Retreatment of previous root canal therapy - anterior	\$155.00
D3347	Retreatment of previous root canal therapy - premolar	\$245.00
D3348	Retreatment of previous root canal therapy - molar	\$395.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$80.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	\$55.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	\$55.00
D3410	Apicoectomy - anterior	\$155.00
D3421	Apicoectomy - premolar (first root)	\$165.00
D3425	Apicoectomy - molar (first root)	\$175.00
D3426	Apicoectomy (each additional root)	\$100.00
D3430	Retrograde filling - per root	\$75.00
D3450	Root amputation - per root	\$85.00
D3471	Surgical repair of root resorption - anterior	\$155.00
D3472	Surgical repair of root resorption - premolar	\$155.00
D3473	Surgical repair of root resorption - molar	\$155.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	\$155.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	\$155.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar ...	\$155.00

D3920	Hemisection (including any root removal), not including root canal therapy	\$75.00
D3921	Decoronation or submergence of an erupted tooth	\$14.00

D4000-D4999 V. PERIODONTICS

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$160.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$95.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$160.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$95.00
D4245	Apically positioned flap	\$175.00
D4249	Clinical crown lengthening - hard tissue	\$150.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$385.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$308.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	\$235.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	\$85.00
D4270	Pedicle soft tissue graft procedure	\$235.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	\$90.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	\$235.00

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	\$235.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$60.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$50.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>1 D1110, D1120 or D4346 per 6 month period</i>	\$5.00
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i>	\$60.00
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i>	\$45.00
D4910	<i>Additional periodontal maintenance (within the 6 month period)</i>	\$55.00
D4921	Gingival irrigation with a medicinal agent - per quadrant	No Cost

D5000-D5899

VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	\$365.00
D5120	Complete denture - mandibular	\$365.00
D5130	Immediate denture - maxillary	\$385.00
D5140	Immediate denture - mandibular	\$385.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$325.00

D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$325.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$395.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$395.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$325.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$325.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$395.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$395.00
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery ...	\$445.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	\$445.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$325.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$325.00
D5410	Adjust complete denture - maxillary	\$18.00
D5411	Adjust complete denture - mandibular	\$18.00
D5421	Adjust partial denture - maxillary	\$18.00
D5422	Adjust partial denture - mandibular	\$18.00
D5511	Repair broken complete denture base, mandibular .	\$55.00
D5512	Repair broken complete denture base, maxillary	\$55.00
D5520	Replace missing or broken teeth - complete denture - per tooth	\$35.00
D5611	Repair resin partial denture base, mandibular	\$55.00
D5612	Repair resin partial denture base, maxillary	\$55.00
D5621	Repair cast partial framework, mandibular	\$55.00

D5622	Repair cast partial framework, maxillary	\$55.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	\$55.00
D5640	Replace missing or broken teeth - partial denture - per tooth	\$45.00
D5650	Add tooth to existing partial denture - per tooth	\$45.00
D5660	Add clasp to existing partial denture - per tooth	\$55.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$180.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$180.00
D5710	Rebase complete maxillary denture	\$105.00
D5711	Rebase complete mandibular denture	\$105.00
D5720	Rebase maxillary partial denture	\$105.00
D5721	Rebase mandibular partial denture	\$105.00
D5725	Rebase hybrid prosthesis	\$105.00
D5730	Reline complete maxillary denture (chairside)	\$60.00
D5731	Reline complete mandibular denture (chairside)	\$60.00
D5740	Reline maxillary partial denture (chairside)	\$60.00
D5741	Reline mandibular partial denture (chairside)	\$60.00
D5750	Reline complete maxillary denture (laboratory)	\$95.00
D5751	Reline complete mandibular denture (laboratory) ..	\$95.00
D5760	Reline maxillary partial denture (laboratory)	\$95.00
D5761	Reline mandibular partial denture (laboratory)	\$95.00
D5765	Soft liner for complete or partial removable denture - indirect	\$95.00
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - <i>limited to 1 in any 12 consecutive months</i>	\$125.00
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - <i>limited to 1 in any 12 consecutive months</i>	\$125.00
D5850	Tissue conditioning, maxillary	\$30.00
D5851	Tissue conditioning, mandibular	\$30.00

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

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

- When a crown and/or pontic exceeds six units in the same treatment plan, You may be charged an additional \$100.00 per unit, beyond the 6th unit.

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

D6210	Pontic - cast high noble metal	\$395.00
D6211	Pontic - cast predominantly base metal	\$295.00
D6212	Pontic - cast noble metal	\$335.00
D6240	Pontic - porcelain fused to high noble metal	\$395.00
D6241	Pontic - porcelain fused to predominantly base metal	\$295.00
D6242	Pontic - porcelain fused to noble metal	\$335.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	\$335.00
D6245	Pontic - porcelain/ceramic	\$395.00
D6250	Pontic - resin with high noble metal	\$335.00
D6251	Pontic - resin with predominantly base metal	\$235.00
D6252	Pontic - resin with noble metal	\$275.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	\$345.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	\$365.00
D6602	Retainer inlay - cast high noble metal, two surfaces	\$295.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	\$305.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	\$195.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	\$205.00
D6606	Retainer inlay - cast noble metal, two surfaces	\$225.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	\$235.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	\$340.00

D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	\$375.00
D6610	Retainer onlay - cast high noble metal, two surfaces	\$300.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	\$310.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	\$200.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	\$210.00
D6614	Retainer onlay - cast noble metal, two surfaces	\$220.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	\$240.00
D6720	Retainer crown - resin with high noble metal	\$335.00
D6721	Retainer crown - resin with predominantly base metal	\$235.00
D6722	Retainer crown - resin with noble metal	\$275.00
D6740	Retainer crown - porcelain/ceramic	\$395.00
D6750	Retainer crown - porcelain fused to high noble metal	\$395.00
D6751	Retainer crown - porcelain fused to predominantly base metal	\$295.00
D6752	Retainer crown - porcelain fused to noble metal ...	\$335.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	\$395.00
D6780	Retainer crown - 3/4 cast high noble metal	\$395.00
D6781	Retainer crown - 3/4 cast predominantly base metal	\$295.00
D6782	Retainer crown - 3/4 cast noble metal	\$335.00
D6783	Retainer crown - 3/4 porcelain/ceramic	\$395.00
D6784	Retainer crown - 3/4 titanium and titanium alloys ..	\$395.00
D6790	Retainer crown - full cast high noble metal	\$395.00
D6791	Retainer crown - full cast predominantly base metal	\$295.00
D6792	Retainer crown - full cast noble metal	\$335.00
D6930	Re-cement or re-bond fixed partial denture	\$25.00
D6940	Stress breaker	\$50.00
D6980	Fixed partial denture repair necessitated by restorative material failure	\$70.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - primary tooth	\$10.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$14.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$55.00
D7220	Removal of impacted tooth - soft tissue	\$70.00
D7230	Removal of impacted tooth - partially bony	\$95.00
D7240	Removal of impacted tooth - completely bony	\$120.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$140.00
D7250	Removal of residual tooth roots (cutting procedure)	\$45.00
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	\$140.00
D7252	Partial extraction for immediate implant placement - <i>Once in a lifetime</i>	\$55.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$130.00
D7280	Exposure of an unerupted tooth	\$120.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$120.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7284	Excisional biopsy of minor salivary glands - <i>does not include pathology laboratory procedures</i>	\$40.00
D7286	Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i>	\$40.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$100.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$100.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	\$120.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	\$120.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost

D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible) .	\$100.00
D7472	Removal of torus palatinus	\$100.00
D7473	Removal of torus mandibularis	\$100.00
D7509	Marsupialization of odontogenic cyst	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	\$25.00
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost
D7970	Excision of hyperplastic tissue - per arch	\$80.00
D7971	Excision of pericoronal gingiva	\$80.00

D8000-D8999 XI. ORTHODONTICS

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

- *The Retention Copayment includes adjustments and/or office visits up to 24 months.*

Pre and post orthodontic records include:

The Benefit for pre-treatment records and diagnostic services includes: \$200.00

D0210	Intraoral - comprehensive series of radiographic images - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted</i>	
D0322	Tomographic survey	
D0330	Panoramic radiographic image - <i>limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted</i>	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intra-orally or extra-orally	
D0396	3D printing of a 3D dental surface scan	
D0470	Diagnostic casts	

- D0801 3D intraoral surface scan - direct
- D0802 3D dental surface scan - indirect
- D0803 3D facial surface scan - direct
- D0804 3D facial surface scan - indirect

The Benefit for post-treatment records includes: \$70.00

- D0210 Intraoral - comprehensive series of radiographic images - *limited to 1 of (D0210 or D0330) per 24 months. Either one (1) D0210 or one (1) D0330 permitted*
- D0470 Diagnostic casts

- D8010 Limited orthodontic treatment of the primary dentition \$1,150.00
- D8020 Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19* \$1,150.00
- D8030 Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19* \$1,150.00
- D8040 Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*\$1,350.00
- D8070 Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*\$1,900.00
- D8080 Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*\$1,900.00
- D8090 Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*\$2,100.00
- D8091 Comprehensive orthodontic treatment with orthognathic surgery - *adults, including covered dependent adult children*\$2,420.00
- D8660 Pre-orthodontic treatment examination to monitor growth and development \$25.00
- D8680 Orthodontic retention (removal of appliances, construction and placement of *removable* retainers) \$275.00
- D8681 Removable orthodontic retainer adjustment No Cost
- D8999 Unspecified orthodontic procedure, by report - *includes treatment planning session* \$100.00

D9000-D9999**XII. ADJUNCTIVE GENERAL SERVICES**

D9110	Palliative treatment of dental pain - per visit	\$20.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	\$80.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	\$80.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	\$80.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment ..	\$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$25.00
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$5.00
D9440	Office visit - after regularly scheduled hours	\$35.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	\$10.00
D9944	Occlusal guard - hard appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$105.00
D9945	Occlusal guard - soft appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$105.00

D9946	Occlusal guard - hard appliance, partial arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$105.00
D9951	Occlusal adjustment, limited	\$55.00
D9952	Occlusal adjustment, complete	\$105.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - <i>limited to one bleaching tray and gel for two weeks of self-treatment</i>	\$125.00
D9986	Missed appointment - <i>without 24 hour notice - per 15 minutes of appointment time</i>	\$10.00
D9987	Canceled appointment - <i>without 24 hour notice - per 15 minutes of appointment time</i>	\$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter ...	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by a Dentist, You pay the specified Copayment. If You seek treatment from Non-Network Dentists You will be responsible for the difference, if any, between the amount We pay and the Non-Network Dentist's submitted fee for such treatment.

Benefits for Non-Network Dentists

Procedures listed above may be performed by a Non-Network Dentist, subject to the Copayments, limitations and exclusions found in *Schedule B* and the following provision:

Benefit Amount: We will pay for covered services received from a Non-Network Dentist at the rate 70 percent of the Maximum Fee allowance for the covered service.

SCHEDULE B

Limitations and Exclusions of Benefits

Limitations

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*.
2. If You accept a treatment plan from the general Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, You may be charged an additional \$100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by an oral surgeon for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age 13. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. Your cost for receiving orthodontic treatment after Your coverage is cancelled or terminated for any reason will be based on the orthodontist's submitted fee for the treatment plan. A Network Orthodontist will prorate the amount for the number of months remaining to complete treatment. You will make payment directly to the Network Orthodontist as arranged. A Non-Network Orthodontist will make payment arrangements directly with You.
6. Orthodontic treatment in progress is available to You, if at the time of Your original effective date, You are in active treatment started under Your previous dental plan, as long as You continue to be eligible under the Plan. Active treatment means tooth movement has begun. You are responsible for all copayments and fees subject to the provisions of Your prior dental plan. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.
7. Benefits for a soft tissue management program are limited to those parts which are listed covered services listed on *Schedule A, Description of Benefits and Copayments*.

8. Teledentistry services provided by a Dentist other than Your DeltaCare USA Dentist are considered out-of-network and may result in an out-of-pocket cost to You.
9. Coverage for orthodontic treatment is limited to conventional orthodontic services, which includes clear aligner therapy (e.g., Invisalign[™] and Sure Smile[™]). We consider lingual brackets, clear (composite or ceramic) brackets to be specialized services. When treatment using lingual brackets or clear (composite or ceramic) brackets is provided, We will make an allowance for conventional orthodontic services. You are responsible for Your Copayment for the conventional orthodontic treatment plus the additional fees related to the specialized services (lingual brackets or clear brackets).

Exclusions

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
 - * has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
 - * is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. The replacement of lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, and crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restorations if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Procedures that may include:
 - * precious metal for removable appliances;
 - * metallic or permanent soft bases for complete dentures;
 - * porcelain denture teeth;
 - * precision abutments for removable partials or fixed partial dentures including but not limited to overlays and related specialized appliances; and/or
 - * personalization and characterization of complete and partial dentures.
8. Consultations for non-covered Benefits.
9. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
10. Prescription drugs.

11. Dental expenses incurred in connection with any dental or orthodontic procedure started before Your enrollment with the Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
12. Lost, stolen or broken orthodontic appliances.
13. Changes in orthodontic treatment necessitated by accident of any kind.
14. Myofunctional and parafunctional appliances and/or therapies with the exception of procedures D9944 (Occlusal guard - hard appliance, full arch), D9945 (Occlusal guard - soft appliance, full arch) and D9946 (Occlusal guard - hard appliance, partial arch);
15. Treatment or appliances that are provided by a Contract Dentist whose practice specializes in prosthodontic services.
16. Any part of a preventive or soft tissue management program which is not a listed covered service in *Schedule A, Description of Benefits and Copayments*.
17. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Դուք կարող եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրաված ձևը լեզվով: Անվճար օգնություն համար ինդրոնթ ենք զանգահարել 1-800-422-4234 (TTY՝ 711): (Armenian)

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

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

צ קענט איר לייענען דעם דאזיקן דאקומענט? אויב ניט, עמעצער דא קען איך העלפן אים צו לייענען. עס איז אויך מעגלעך, אז איר קענט באקומען דעם דאזיקן דאקומענט אין איינער שפראך. פאר אומזיסטע הילף קענט איר אנקלינגען אַט די דאזיקע נומער: 1-800-422-4234 ס'איז דא א נומער פאר מענטשען, וואס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bííníghah? Doo bííníghahgóó éí nich'í' yídóol'tahígíí nihee hóló. Díí naaltsoos t'áá Diné bizaad k'éhjí ályaago ałdó' nich'í' ádoolnǫ́łgo bííghah. T'áá jíík'e shíká i'doolwoł nínízingo kojí' béésh holdílnih 1-800-422-4234 (TTY: 711) (Navajo)

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

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

Toll Free
800-422-4234

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