Flexible Spending Account (FSA) – TaxSaver

TaxSaver administers the Flexible Spending Accounts. FSAs allow you to pay for eligible health care and dependent care using tax-free dollars. There are two types of FSAs – the Health Care FSA and the Dependent Care FSA.

Health Care FSA

The Health Care FSA allows Employees to pay for certain IRS-approved medical care expenses not covered by their insurance plan with pre-tax dollars.

The 2024 annual maximum amount you may contribute to the Health Care FSA is $3,050, pretax.

You will receive a debit card to pay for eligible medical expenses (funds must be available in your account). Examples of qualified medical expenses include copays, prescription expenses, lab exams and tests, contact lenses and eyeglasses. A list of eligible expenses can be found at: **www.irs.gov/pub/irs-pdf/p502.pdf**.

At the end of the calendar year, participants can roll over eligible, unused health care funds.

Dependent Care FSA

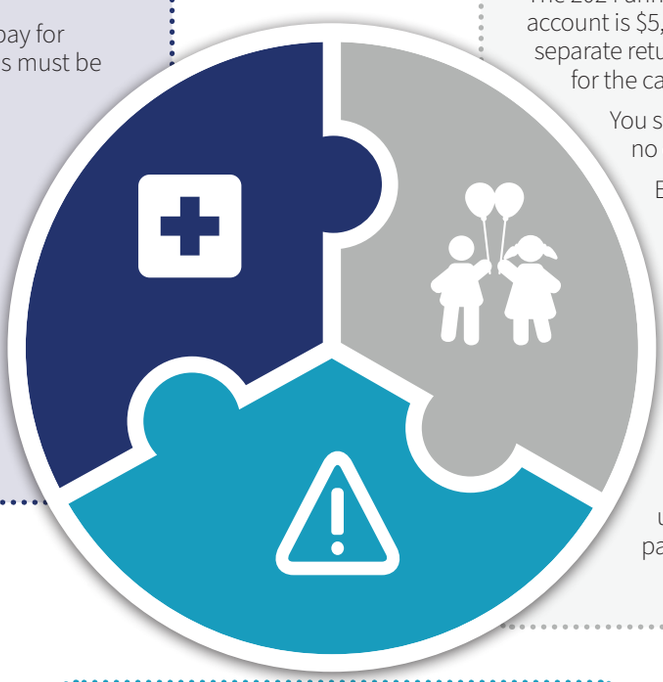
The Dependent Care FSA allows you to set aside pre-tax dollars to pay for dependent care for children up to age 13, a disabled dependent of any age or a disabled spouse. To be eligible, you and your spouse (if applicable) must work, be looking for work or be full-time students.

The 2024 annual IRS limit for this type of account is $5,000. If you are married and file separate returns, you can each elect $2,500 for the calendar year.

You submit claims for reimbursement; no debit cards are provided.

Examples of eligible expenses include preschool, summer day camp, before or after school programs, and child or elder daycare. A list of eligible expenses can be found at: **www.irs.gov/pub/irs-pdf/p503.pdf**.

You cannot use your Health Care FSA to pay for Dependent Care expenses, and you cannot use your Dependent Care FSA to pay for health care expenses.



Use It or Lose It

Submit claims by **March 31, 2025**, for expenses from January 1 to December 31, 2024.

IRS "use it or lose it" rules apply. If you don't spend all the funds in your current-year FSAs by March 15 of next year (and submit your claims by March 31), you may lose them.

The Health Care FSA allows you to roll over up to $610 unused funds to the next plan year and they can be used anytime in 2024.

Commuter Benefits

Contribute $300 per month, pretax, to pay for your parking or public transportation expenses while commuting to work, including monthly passes, tokens or fare cards. This program, administered by TaxSaver Plan, is voluntary and you may participate on a month-to-month basis. Both payroll contributions and reimbursements cannot exceed the monthly statutory limits. Unused funds in any month are rolled over to the next month's contribution. To learn more about this program, click **here**.

CLUBCORP
FLEXIBLE SPENDING ACCOUNT PLAN

SUMMARY PLAN DESCRIPTION

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SUMMARY

CLUBCORP
FLEXIBLE SPENDING ACCOUNT PLAN

INTRODUCTION

We have amended the "Flexible Benefits Plan" that we previously established for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

I
ELIGIBILITY

1. When can I become a participant in the Plan?

Before you become a Plan member (referred to in this Summary Plan Description as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain application forms before you can enroll in the Plan.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan 1st of the month following date of hire. Of course, if you were already a participant before this amendment, you will remain a participant.

3. When is my entry date?

You can join the Plan on the day you meet the eligibility requirements.

4. Are there any employees who are not eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are:

-- Employees who are part-time. A part-time employee is someone who works, or is expected to work, less than 30 hours a week.

-- Employees who are considered "self-employed individuals" under the Federal tax law. A sole proprietor is a "self-employed individual" and therefore is not eligible to participate.

5. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

II
OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.")

III
CONTRIBUTIONS

1. How much of my pay may the Employer redirect?

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

2. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

3. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

4. When is the election period for our Plan?

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

5. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

-- Marriage, divorce, death of a spouse, legal separation or annulment;

-- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

-- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;

-- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and

-- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

You may revoke your coverage under the employer's group health plan outside of our open enrollment period, if your employment status changes from working at least 30 hours per week to less than 30 hours. This is regardless of whether the reduction in hours has resulted in loss of eligibility. You must show intent to enroll in another health plan.

You may also revoke your coverage under our Employer sponsored group health plan if you are eligible to obtain coverage through the health exchanges.

6. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year.

IV
BENEFITS

1. Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

(a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;

(b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and

(c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Ask your tax adviser which is better for you.

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

2. What happens if I don't spend all Plan contributions during the Plan Year?

Any monies left at the end of the Plan Year will be forfeited. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the Dependent Care

Flexible Spending Account, you must submit claims no later than 120 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. Family and Medical Leave Act (FMLA)

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

4. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

(a) You will still be able to request reimbursement for qualifying dependent care expenses incurred during the remainder of the Plan Year from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 120 days after the end of the Plan Year in which termination occurs.

5. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII
PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

ClubCorp Flexible Spending Account Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of your amended Plan become effective on January 1, 2018. Your Plan was originally effective on January 1, 2007.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

2. Employer Information

Your Employer's name, address, and identification number are:

ClubCorp USA, Inc.
3030 LBJ Freeway, Suite 600
Dallas, Texas 75234
75-2114856

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

ClubCorp USA, Inc.
3030 LBJ Freeway, Suite 600
Dallas, Texas 75234
(972) 888-7366

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:
ClubCorp USA, Inc.
3030 LBJ Freeway, Suite 600
Dallas, Texas 75234

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

PayFlex Systems USA, Inc.
PO Box 981158
El Paso, TX 79998-1158

IX
ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. For those benefits subject to ERISA, these laws provide that Participants, eligible employees and all other employees are entitled to:

(a) examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;

(b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies;

(c) continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage; and

(d) review this summary plan description and the documents governing the plan on the rules governing COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 120 days after the end of the Plan Year. Any claims submitted after that time will not be considered.

If a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

X
SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

Medical Benefits Overview

Invited offers several options of medical plans to meet your specific needs. Please take the time to review the detailed materials to understand each option.

	Aetna SimplePay Health Plan		UHC High Deductible Health Plan		UHC Choice Plus PPO Plan		UHC Minimum Essential Coverage	
Per Paycheck Deductions	$$$		$$		$$$$		$	
Insurance Company	Aetna/CVS Health		UHC/OptumRx		UHC/OptumRx		UHC/OptumRx	
Network Coverage	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network
Preventive Care Services	Free	Not Covered	Free	Not Covered	Free	Not Covered	Free	Not Covered
Medical Telehealth Visit (HealthJoy)		Not Applicable		Not Applicable		Not Applicable		Not Applicable
Mental Telehealth Visit (HealthJoy)		Not Applicable		Not Applicable		Not Applicable		Not Applicable
Primary Care Physician Visit	Tier 1 $30 Tier 2 $40 Tier 3 $70	Tier 1 $85 Tier 2 $85 Tier 3 $85	Tier 1 Deductible then 20% Tier 2 Deductible then 40%	Deductible then 60%	Tier 1 $10 Tier 2 $40	Deductible then 60%	$25	Not Covered
Yearly Deductible	None Copays per Service	None Copays per Service	Individual $4,000 Family $8,000	Individual $10,000 Family $20,000	Individual $2,500 Family $6,250	Individual $4,000 Family $10,000	Not Applicable	Not Covered
Coinsurance	None Copays per Service	None Copays per Service	Tier 1 20% Tier 2 40%	Deductible then 60%	Tier 1 20% Tier 2 40%	Deductible then 60%	Not Applicable	Not Covered
Pretax Savings Account	Health Flexible Spending Account Up to $3,050		Health Savings Account Up to $4,150 Individual or Up to $8,300 Family		Health Flexible Spending Account Up to $3,050		Health Flexible Spending Account Up to $3,050	

*__Out-of-Network__: In addition to the out-of-pocket responsibility noted above, you are responsible for any costs charged by the provider that exceed the reasonable charge as determined by the health plan.

Medical Benefits Paycheck Deductions

Tier	AETNA SIMPLEPAY HEALTH PLAN			
	Bi-Weekly	Spousal Surcharge	Smoking Surcharge	Spousal + Smoking Surcharge
Employee Only	$79.38	N/A	$154.38	N/A
Employee + Spouse	$238.15	$313.15	$313.15	$388.15
Employee + Child(ren)	$196.03	N/A	$271.03	N/A
Employee + Family	$299.72	$374.72	$374.72	$449.72
Tier	**UHC HIGH DEDUCTIBLE HEALTH PLAN**			
	Bi-Weekly	Spousal Surcharge	Smoking Surcharge	Spousal + Smoking Surcharge
Employee Only	$43.92	N/A	$118.92	N/A
Employee + Spouse	$197.64	$272.64	$272.64	$347.64
Employee + Child(ren)	$158.11	N/A	$233.11	N/A
Employee + Family	$254.74	$329.74	$329.74	$404.74
Tier	**UHC CHOICE PLUS PPO PLAN**			
	Bi-Weekly	Spousal Surcharge	Smoking Surcharge	Spousal + Smoking Surcharge
Employee Only	$104.37	N/A	$179.37	N/A
Employee + Spouse	$313.11	$388.11	$388.11	$463.11
Employee + Child(ren)	$257.73	N/A	$332.73	N/A
Employee + Family	$394.05	$469.05	$469.05	$544.05
Tier	**UHC HEALTHY START MEC PLAN**			
	Bi-Weekly	Spousal Surcharge	Smoking Surcharge	Spousal + Smoking Surcharge
Employee Only	$29.00	N/A	$104.00	N/A
Employee + Spouse	$52.08	$127.08	$127.08	$202.08
Employee + Child(ren)	$52.08	N/A	$127.08	N/A
Employee + Family	$52.08	$127.08	$127.08	$202.08

NEW Aetna SimplePay Health Plan

Experience an entirely new health plan. With SimplePay, you no longer have to worry about deductibles, coinsurance or bills from your provider. Use the QR code to see if your current provider is in SimplePay's network.

SimplePay is designed to help you find high-quality, low-cost providers so you don't have to sacrifice getting great care to save money. With SimplePay, providers are categorized into three copay rankings based on the following criteria:

Quality
Providers that have best in class training and certifications, aligned with good care outcomes.

Relationship
Providers that are associated with top quality service lines at their facility.

Experience
Providers that deliver positive patient experiences and outcomes.

Efficiency
Providers that deliver the best care outcome by providing the appropriate amount of care.

Provider Ranking Legend

✓ Tier 1 Provider	— Tier 2 Provider	! Tier 3 Provider
✓ Meets all standards above	— Meets most standards above	! Meets minimum standards above

You get one monthly statement and the option to pay your medical bills out over time with 0% financing, with a credit card, link to your bank account or through payroll deductions. Additionally, when you pay your bill in full, you will receive 1.5% cash back to use towards your next bill! SimplePay is designed to save you time and money so you can spend time on the things you love.

Plan Highlights	SimplePay Health Plan		
Network	Aetna Choice POS2		
Calendar Year Deductible			
Individual Deductible	None		
Family Deductible	None		
Coinsurance	None		
Calendar Year Out-of-Pocket Max			
Individual Out-Of-Pocket	$6,500		
Family Out-of-Pocket	$13,000		
Office Visit			
PCP Office Visit	**Tier 1:** $30 / **Tier 2:** $40 / **Tier 3:** $70		
Specialist Office Visit	**Tier 1:** $65 / **Tier 2**: $85 / **Tier 3:** $140		
General Medical Telemedicine (HealthJoy)	$0		
Mental Health Telemedicine (HealthJoy)	$0		
Urgent Care	**Tier 1:** $65 **Tier 2:** $85 and **Tier 3:** $140		
Hospital Services			
Inpatient Hospital	Varies by Treatment **Tier 1:** $3,130 / **Tier 2:** $4,175 / **Tier 3:** $6,500		
Outpatient Hospital	Varies by Surgery **Tier 1:** $1,020 / **Tier 2:** $1,355 / **Tier 3:** $2,260		
Diagnostic Services			
Routine Labs	**Tier 1:** $20 / **Tier 2:** $30 / **Tier 3:** $45		
Diagnostic Radiology/Labs	**Tier 1:** $90 / **Tier 2:** $120 / **Tier 3:** $195		
Advanced Imaging	**Tier 1:** $315 / **Tier 2:** $415 / **Tier 3:** $695		
Emergency Medical Care			
Emergency Room	$580		
Retail Pharmacy (30-day supply)	**CVS Pharmacy**	**In-Network Pharmacies Excluding CVS/Walgreens**	**WalgreensPharmacy**
Affordable Care Act Generic Drug	No Charge	No Charge	No Charge
Preventive Generic Drug	N/A	N/A	N/A
Generic Drug	$20 Copay	$25 Copay	$40 Copay
Preferred Brand Drug	$50 Copay	$60 Copay	$100 Copay
Non-Preferred Brand Drug	$75	$90	$150
Specialty Drugs	$100	$100	$100

NEW Aetna SimplePay Health Plan

With SimplePay, you no longer have to worry about deductibles, coinsurance or bills from your provider. The SimplePay App identifies top quality providers and shows you a price for every medical service, giving you control over your health care decisions.

How is SimplePay different from the UnitedHealthcare (UHC) medical plan options?

- **No Deductibles:** SimplePay has no annual deductible — you pay a flat dollar amount (called a copay) for all medical services and prescriptions from day one.
- **Out-of-Pocket Cost Certainty:** Know the price of every medical service ahead of time. No upfront out-of-pocket costs, add-ons or surprise bills.
- **Great Care and Value:** Easily locate high-quality providers at a predetermined cost for all services on the SimplePay App — from checkups to advanced procedures.
- **Payments are Made to SimplePay:**
  - When you visit a doctor or a facility for medical services, your provider will not collect your payment.
  - When you fill prescriptions through a network pharmacy, the pharmacy will not collect your payment.
  - Instead, SimplePay will track all your out-of-pocket costs (copays) and then send you a monthly statement.
  - SimplePay offers 0% financing for medical services and prescriptions.
- **Health Valet Service:** Your Health Valet can assist with a variety of different needs, such as finding quality providers, coordinating appointments with providers and answering questions on billing or coverage information.

High Quality Care Is Now Affordable

SimplePay is designed to help you find high-quality, low-cost providers so you don't have to sacrifice getting great care to save money. With SimplePay, providers are categorized into three copay rankings:



Tier 1 Providers

High quality, low cost

Tier 2 Providers

Good quality, medium cost

Tier 3 Providers

Ok quality, high cost

What SimplePay Tier are your providers in? Go to **https://employers.simplepayhealth.com/Invited** and enter your provider's name to check.

The SimplePay Payment Plan Is Easy

- Single monthly statement
- No payment at the time of service
- 0% financing
- Pay manually or autopay
- 1.5% cash back when you pay your bill in full

Why Sign the Member Financial Onboarding Form?

In order to offer 0% financing with no background check you are required to sign a financial onboarding form and provide a payment method (e.g., bank account, credit card, paycheck, etc.) to receive your financial benefits.

BILL PAYMENT IS DIFFERENT Knee Surgery at an Outpatient Facility	
TODAY	**SIMPLEPAY**
Member receives bills & EOBs for each provider.	**Member receives one monthly statement from SimplePay.**
All bills apply towards your deductible: UHC Choice Plus PPO $2,500 NEW UHC HDHP $4,000	No annual deductible: All bills are consolidated into a single copay.
Anesthesia Bill: You owe $$$	All Providers: You owe $1,020 (Tier 1)
Radiology Facility: You owe $$$	
Radiologist: You owe $$$	
Pathologist: You owe $$$	
Surgeon: You owe $$$$	
Surgery Center: You owe $$$$	
You pay each provider directly - typically, payment is required upfront.	You pay SimplePay directly - no payment is required upfront.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.simplepayhealth.com or call (814) 772-3850. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call SimplePay Health at (800) 606-3564 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. All services are covered before you meet a deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers: $6,500 person / $13,000 family For non-participating providers: Unlimited per person & family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.simplepayhealth.com or call (800) 606-3564 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 - $70 copay/visit	$85 copay/visit	Includes telemedicine other than Teladoc. You pay $0 copay if you receive telephone consultation services through Teladoc. You pay $0 copay for services received at a MinuteClinic.
	Specialist visit	$65 - $140 copay/visit	$170 copay/visit	
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$90 - $195 copay/visit	$235 copay/visit	----------none----------
	Imaging (CT/PET scans, MRIs)	$315 - $695 copay/scan	$835 copay/scan	Preauthorization recommended for PET scans and non-orthopedic CT/MRI's.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$20 copay - $40 copay (retail) / $40 copay (EDSN & mail order)	Not Covered	Covers up to a 30-day supply (retail prescription); 90-day supply (Extended Days Supply Network (EDSN) or mail order prescription); 30-day supply (specialty drugs). The copay applies per prescription. There is no charge for preventive drugs. Dispense as Written (DAW) provision applies. Step therapy provision applies. Specialty drugs must be obtained directly from the specialty pharmacy. *Certain specialty drugs may be eligible for a $0 copay if you are enrolled under the PrudentRx Solutions Program. If drugs are eligible under the Prudent Rx Solution Program and you do not enroll you will be subject to a 30% copay. Certain specialty drugs are eligible for copay assistance programs through CVS True Accumulation Program.
	Preferred brand drugs	$50 copay - $100 copay (retail) / $100 copay (EDSN & mail order)	Not Covered	
	Non-preferred brand drugs	$75 copay - $150 copay (retail) / $150 copay (EDSN & mail order)	Not Covered	
	Specialty drugs	$100 copay*	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,020 - $2,260 copay/ occurrence	$2,710 copay	Preauthorization recommended for certain surgeries. See your plan document for a detailed listing.
	Physician/surgeon fees	No Charge	No Charge	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$580 copay/visit (emergency services)/ Not Covered (non-emergency services)	$580 copay/visit (emergency services)/ Not Covered (non-emergency services)	Non-participating providers paid at the participating provider level of benefits for emergency services.
	Emergency medical transportation	$580 copay/trip	$580 copay/trip	Non-participating providers paid at the participating provider level of benefits.
	Urgent care	$65 - $140 copay/visit	$170 copay/visit	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$3,130 - $6,500 copay/ admission	$7,800 copay/admission	Preauthorization recommended.
	Physician/surgeon fees	No Charge	No Charge	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 - $70 copay/visit (office visit) / $1,020 - $2,260 copay/visit (all other outpatient)	$85 copay/visit (office visit) / $2,710 copay/visit (all other outpatient)	Includes telemedicine other than Teladoc.
	Inpatient services	$3,130 - $6,500 copay/ admission (facility charges)/ No Charge (professional fees)	$7,800 copay/admission (facility charges)/ No Charge (professional fees)	Preauthorization recommended.
If you are pregnant	Office visits	Office: $30 - $70 copay/ visit / Outpatient: $550 - $1,235 copay/visit / Diagnostic tests: $90 - $195 copay/visit	Office: $85 copay/visit / Outpatient: $1,500 copay/visit / Diagnostic tests: $235 copay/visit	Preauthorization recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). Cost sharing does not apply to preventive services from a participating provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense.
	Childbirth/delivery professional services	No Charge	No Charge	
	Childbirth/delivery facility services	$3,130 - $6,500 copay/ admission	$7,800 copay/admission	
If you need help recovering or have other special health needs	Home health care	$65 - $140 copay/visit	$170 copay/visit	Limited to 30 visits per year. Preauthorization recommended.
	Rehabilitation services	$65 - $140 copay/visit	$170 copay/visit	Physical, occupational, & speech/ hearing therapy limited to 30 visits per each type of therapy per.
	Habilitation services	$65 - $140 copay/visit	$170 copay/visit	
	Skilled nursing care	$2,765 - $6,145 copay/ admission	$7,375 copay/admission	Limited to 25 days per year. Preauthorization recommended.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Durable medical equipment	$140 - $315 copay/item	$380 copay/item	Preauthorization recommended for electric/motorized scooters or wheelchairs and pneumatic compression devices.
	Hospice services	$340 - $755 copay/ services	$905 copay/services	For bereavement counseling, you pay a $65 - $140 copay/visit for participating providers; $170 copay/visit for non-participating providers.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Some pediatric eye screenings are covered under preventive services.
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- **Acupuncture**
- **Cosmetic surgery**
- **Dental care (Adult & Child)**
- **Emergency room services for non-emergency services**
- **Glasses (Adult & Child)**
- **Hearing aids**
- **Infertility treatment (except diagnosis and correction of underlying medical condition)**
- **Long-term care**
- **Non-emergency care when traveling outside the U.S.**
- **Private-duty nursing (outpatient - except for home health care & hospice)**
- **Routine eye care (Adult & Child)**
- **Routine foot care (except for metabolic or peripheral vascular disease)**
- **Weight loss programs**

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- **Bariatric surgery (for morbid obesity only)**
- **Chiropractic care**
- **Private-duty nursing (inpatient)**

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or Club Corp USA INC dba Invited at (814) 772-3850. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or Club Corp USA INC dba Invited at (814) 772-3850.

Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Consumer Health Assistance Program, Texas Department of Insurance at (800) 252-3439.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-378-1179.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Primary care copayment** **$550-$1,235**
- **Hospital (facility) copayment** **$3,130-$6,600**
- **Other copayment** **$0-$6,500**

This EXAMPLE event includes services like:
Primary care physician visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$6,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$6,560

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$65-$140**
- **Hospital (facility) copayment** **$550-$1,235**
- **Other copayment** **$0-$6,500**

This EXAMPLE event includes services like:
Specialist office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,620

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$65-$140**
- **Hospital (facility) copayment** **$580**
- **Other copayment** **$0-$6,500**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2.200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,200

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

UnitedHealthcare

UnitedHealthcare Choice Plus PPO Plan

Choice Plus is a Preferred Provider Organization (PPO) which means you can choose any provider in the Choice Plus Network, as well as non-network providers. You receive the highest benefit by using Choice Plus Network providers, and can also take advantage of copays for office visits and some prescription drugs.

You can lower your out-of-pocket cost by using Tier 1 Providers. Locate Tier 1 Providers at **www.myuhc.com** or by scanning the QR code — look for the blue dot to identify if your doctor is a Tier 1 Provider in the online provider finder.

Plan Highlights	Choice Plus PPO Plan
Network	Choice Plus
Calendar Year Deductible	
Individual / Family	$2,500 / $6,250
Coinsurance (you pay)	Tier 1: 20% / Tier 2: 40%
Calendar Year Out-of-Pocket Max	
Individual / Family	$7,900 / $15,800
Office Visit	
Primary Care Physician (PCP)	Tier 1: $10 Copay / Tier 2: $40 Copay
Specialist	Tier 1: $30 Copay / Tier 2: $90 Copay
Preventive Care Services	No Charge
General Medical Telemedicine (HealthJoy)	No Charge
Mental Health Telemedicine (HealthJoy)	No Charge
Urgent Care	$100 Copay
Hospital Services	
Inpatient Hospital	Tier 1: Deductible then 30% / Tier 2: $500 copay, Deductible then 50%
Outpatient Surgery	Tier 1: $400 copay / Tier 2: $650 copay
Diagnostic Services	
Cat Scans/MRIs	Freestanding Facility: $200 Copay Hospital: $400 Copay
Emergency Medical Care	
Emergency Room	$250 Copay, Deductible then 30% coinsurance
Retail Pharmacy (30-day supply)	
Affordable Care Act Generic Drug	No Charge
Preventive Generic Drug	N/A
Generic Drug	$15 Copay
Preferred Brand Drug	$40 Copay
Non-Preferred Brand Drug	Deductible then 30% ($180 min or cost of drug, whichever is less)
Specialty	30% Coinsurance (no Deductible: $150/$300 max)
Mail Order (90-day supply)	
Preferred Generic	No Charge
Non-Preferred Generic	$30 Copay
Preferred Brand	$80 Copay
Non-Preferred Brand	Deductible then 30% ($360 min or cost of drug, whichever is less)
Specialty	30% Coinsurance (no Deductible: $150/$300 max)
Out-of-Network	
Calendar Year Deductible	
Individual / Family	$4,000 / $10,000
Coinsurance	60%
Calendar Year Out-of-Pocket Max	
Individual / Family	$75,000 / $150,000

The above information is a summary only. Please refer to your Certificate of Coverage for complete details of Plan benefits, limitations and exclusions.

UnitedHealthcare

Choice Plus Plan

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit https://www.myuhc.com/ or call 1-800-865-9386. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-800-865-9386 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network*: $2,500 Individual / $6,250 Family Non-Network*: $4,000 Individual / $10,000 Family per calendar year. *Deductibles cross-apply	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care and primary care services with copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For network provider*: $7,900 Individual / $15,800 Family For out-of-network providers*: $75,000 Individual / $150,000 Family per calendar year *Out-of-pockets cross-apply	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the out-of-pocket.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See https://www.myuhc.com/ or call 1-800-865-9386 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Tier 1: $10 copay/visit Tier 2: $40 copay/visit	60% coinsurance	In Network Virtual visits 0% coinsurance, no deductible by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. No virtual visit coverage for out of network.
	Specialist visit	Tier 1: $30 copay/visit Tier 2: $90 copay/visit	60% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	60% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	Freestanding Facility: $300 copay Hospital: $400 copay/visit	60% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Preventive Generic	Retail: No Charge Mail Order: No Charge	Not Covered	Retail – up to 30-day supply Mail Order – up to 90-day supply
	Other Generic	Retail: $15 copay Mail Order: $30 copay	Not Covered	Retail – up to 30-day supply Mail Order – up to 90-day supply
	Preferred brand	Retail: $40 copay Mail Order: $80 copay	Not Covered	Retail – up to 30-day supply Mail Order – up to 90-day supply
	Non-Preferred Brand	Retail: Ded then 30%; lesser of $180 copay or cost of drug; Mail Order: Ded then 30%; lesser of $360 copay or cost of drug;	Not Covered	Retail – up to 30-day supply Mail Order – up to 90-day supply
	Specialty	Retail: 30% (no ded: $150/$300 max)	Not Covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Tier 1: $400 copay/visit Tier 2: $650 copay/visit	60% coinsurance	Tier 1 Freestanding Facility & ASC copay $400 no deductible, 100% coins
	Physician/surgeon fees	40% coinsurance	60% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay/visit, 30% coinsurance	$250 copay/visit 30% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$100 copay/visit	60% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/visit, 50% coinsurance after deductible	60% coinsurance	None
	Physician/surgeon fees	40% coinsurance	60% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit	60% coinsurance	Cognitive Behavioral Therapy provided by AbleTo is covered at 100% no cost share for the initial consultation and ongoing therapeutic treatments. AbleTo is a contracted provider for Optum Behavioral services specifically for Cognitive Behavioral Therapy. Partial Hospitalization/Intensive Outpatient Treatment In- Network - No charge. Prior Authorization is also required for Benefits provided for Applied Behavioral Analysis (ABA). Telehealth services covered with $0 copay, no deductible and 100% coinsurance INN Only.
	Inpatient services	30% coinsurance	60% coinsurance	None
If you are pregnant	Office visits	$40 copay/initial visit only	60% coinsurance	Routine pre-natal care is covered at no charge
	Childbirth/delivery professional services	40% coinsurance	60% coinsurance	
	Childbirth/delivery facility services	$500 copay/visit, 50% coinsurance	60% coinsurance	
If you need help recovering or have	Home health care	40% coinsurance	60% coinsurance	Limited to 30 visits per calendar year.
	Rehabilitation services	$30 copay/visit	60% coinsurance	Limits per calendar year: Physical, Speech, Occupational; 30 visits each.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs	Habilitation services	Not covered	Not covered	Not Covered
	Skilled nursing care	30% coinsurance	60% coinsurance	Limited to 25 days per calendar year.
	Durable medical equipment	40% coinsurance	60% coinsurance	None
	Hospice services	40% coinsurance	60% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for Children's eye exams.
	Children's glasses	Not covered	Not covered	No coverage for Children's glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Adult routine vision exam (i.e. refraction)
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic care
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov/ or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-800-865-9386 or visit https://www.myuhc.com/ or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? No

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-865-9386.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-865-9386.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-865-9386.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-865-9386.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ **The plan's overall deductible**	**$2,500**
■ **Specialist copayment**	**$90**
■ **Hospital (facility) copayment**	**$500**
■ **Other coinsurance**	**40%**

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$500
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$4,270**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$2,500**
■ **Specialist copayment**	**$90**
■ **Hospital (facility) copayment**	**$500**
■ **Other coinsurance**	**40%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,900**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$2,500**
■ **Specialist copayment**	**$90**
■ **Hospital (facility) copayment**	**$500**
■ **Other coinsurance**	**40%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,410**

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 **(Korean)** 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリー
ダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) **के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।**

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាបង់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).

UnitedHealthcare

*NEW*UnitedHealthcare High Deductible Health Plan

For 2024, Invited now offers a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA). If you elect the HDHP, you can make pretax contributions to a savings account to help pay for out-of-pocket health care costs and/or save for retirement. Use the QR code to see if your current provider is in UHC's network.

To have the advantage of contributing to an HSA, HDHPs are required to meet certain deductible requirements per the IRS. With the exception of preventive care services (e.g., annual physicals, health screenings and immunizations), you pay the contracted rate that has been negotiated between UHC and your provider (e.g., physician, pharmacy, etc.). Once your total out-of-pocket costs reach the deductible, you begin paying 20% of any remaining out-of-pocket costs until you reach your out-of-pocket maximum.

Plan Highlights	HDHP Plan
Network	Nexus
Calendar Year Deductible	
Individual / Family	$4,000 / $8,000
Coinsurance	Tier 1: 20% / Tier 2: 40%
Calendar Year Out-of-Pocket Max	
Individual / Family	$8,000 / $16,000
Office Visit	
Primary Care Physician (PCP)	Tier 1: 20% after Deductible / Tier 2: 40% after Deductible
Specialist	Tier 1: 20% after Deductible / Tier 2: 40% after Deductible
Preventive Care Services	No Charge
General Medical Telemedicine (HealthJoy)	No Charge
Mental Health Telemedicine (HealthJoy)	No Charge
Urgent Care	Tier 1: 20% after Deductible / Tier 2: 40% after Deductible
Hospital Services	
Inpatient Hospital	Tier 1: 20% after Deductible / Tier 2: 40% after Deductible
Outpatient Surgery	Tier 1: 20% after Deductible / Tier 2: 40% after Deductible
Diagnostic Services	
Cat Scans/MRIs	Freestanding Facility: $300 Copay Hospital: $400 Copay
Nuclear Medicine	
Emergency Medical Care	
Emergency Room	$250 Copay, Deductible, then coinsurance
Retail Pharmacy (30-day supply)	
Affordable Care Act Generic Drug	No Charge, in-network only
Preventive Generic Drug	No Charge, in-network only
Generic Drug	20% coinsurance after deductible
Preferred Brand Drug	20% coinsurance after deductible
Non-Preferred Brand Drug	30% coinsurance after deductible
Specialty	50% coinsurance after deductible
Mail Order (90-day supply)	
Preventive Generic	No Charge
Other Generic	20% coinsurance after deductible
Preferred Brand Drug	20% coinsurance after deductible
Non-Preferred Brand Drug	30% coinsurance after deductible
Specialty	50% coinsurance after deductible
Out-of-Network	
Calendar Year Deductible	
Individual / Family	$10,000 / $20,000
Coinsurance	60%
Calendar Year Out-of-Pocket Max	
Individual / Family	$75,000 / $150,000

The above information is a summary only. Please refer to your Certificate of Coverage for complete details of Plan benefits, limitations and exclusions.

UnitedHealthcare

High Deductible Plan

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit https://www.myuhc.com/ or call 1-888-331-3408. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-888-331-3408 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network*: $4,000 Individual / $8,000 Family Non-Network*: $10,000 Individual / $20,000 Family per calendar year. *Deductibles cross-apply	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For network provider*: $8,000 Individual / $16,000 Family For out-of-network providers*: $75,000 Individual / $150,000 Family per calendar year *Out-of-pockets cross-apply	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the out-of-pocket.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See https://www.myuhc.com/or call 1-888-331-3408 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Tier 1: 20% coinsurance Tier 2: 40% coinsurance	60% coinsurance	In Network Virtual visits 0% coinsurance, no deductible by a Designated Virtual Network Provider. If you receive services in addition to office visit, deductibles, or co-ins may apply. No virtual visit coverage for out of network.
	Specialist visit	Tier 1: 20% coinsurance Tier 2: 40% coinsurance	60% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	60% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	60% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Preventive Generic	Retail: No charge Mail Order: No charge	Not covered	Retail – up to 30-day supply Mail Order – up to 90-day supply
	Other Generic	Retail: Ded, 20% Mail Order: Ded, 20%	Not covered	Retail – up to 30-day supply Mail Order – up to 90-day supply
	Preferred Brand	Retail: Ded, 20% Mail Order: Ded, 20%	Not covered	Retail – up to 30-day supply Mail Order – up to 90-day supply
	Non-Preferred Brand	Retail: Ded, 30% Mail Order: Ded, 30%	Not Covered	Retail – up to 30-day supply Mail Order – up to 90-day supply
	Specialty	Retail: Ded, 50% Mail Order: Ded, 50%	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Tier 1: 20% coinsurance Tier 2: 40% coinsurance	60% coinsurance	None
	Physician/surgeon fees	40% coinsurance	60% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay, 20% coinsurance	$250 copay, 20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	60% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1: 20% coinsurance Tier 2: 40% coinsurance	60% coinsurance	None
	Physician/surgeon fees	Tier 1: 20% coinsurance Tier 2: 40% coinsurance	60% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	60% coinsurance	Partial Hospitalization/Intensive Outpatient Treatment In- Network - 20% coinsurance. Cognitive Behavioral Therapy provided by AbleTo is covered at 100% no cost share for initial consultation; ongoing therapeutic treatments are payable at 100% after in Network plan deductible is satisfied. AbleTo is a contracted provider for Optum Behavioral services specifically for Cognitive Behavioral Therapy. Prior Authorization is also required for Benefits provided for Applied Behavioral Analysis (ABA). Telehealth services covered with $0 copay, no deductible and 100% coinsurance INN Only.
	Inpatient services	20% coinsurance	60% coinsurance	None
If you are pregnant	Office visits	40% coinsurance	60% coinsurance	
	Childbirth/delivery professional services	20% coinsurance	60% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	60% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	60% coinsurance	Limited to 30 visits per calendar year.
	Rehabilitation services	20% coinsurance	60% coinsurance	Limits per calendar year: Physical, Speech, Occupational; 30 visits each.
	Habilitation services	Not covered	Not covered	Not Covered

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	60% coinsurance	Limited to 25 days per calendar year.
	Durable medical equipment	20% coinsurance	60% coinsurance	None
	Hospice services	20% coinsurance	60% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for Children's eye exams.
	Children's glasses	Not covered	Not covered	No coverage for Children's glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Adult routine vision exam (i.e. refraction)
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic care
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov/ or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-888-331-3408 or visit https://www.myuhc.com/ or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? No

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-331-3408.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-331-3408.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-331-3408.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-331-3408.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ **The plan's overall deductible**	**$4,000**
■ **Specialist coinsurance**	**40%**
■ **Hospital (facility) coinsurance**	**40%**
■ **Other coinsurance**	**40%**

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$0
Coinsurance	$3,400
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$7,470**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$4,000**
■ **Specialist coinsurance**	**40%**
■ **Hospital (facility) coinsurance**	**40%**
■ **Other coinsurance**	**40%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$5,200**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$4,000**
■ **Specialist coinsurance**	**40%**
■ **Hospital (facility) coinsurance**	**40%**
■ **Other coinsurance**	**40%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,610**

The plan would be responsible for the other costs of these EXAMPLE covered services

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 **(Korean)** 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリー
ダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) **के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।**

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការ៉ាបង់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit us at https://www.flexwork.uhc.com or by calling **1-855-892-2401.** For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call **1-855-892-2401** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copayment are covered before you meet your deductible.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network Providers: $9,100 individual / $18,200 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, charges exceeding allowed amount, penalties for failure to obtain prior authorization for services, and allowed amounts exceeding plan limits.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.flexwork.uhc.com or call **1-855-892-2401** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit.	Not Covered	4 office visit limit/year, combined sickness, injury, mental health, substance abuse services, pregnancy and specialist visits. Members can also receive limited care via HealthiestYou Telehealth Services consultations.
	Specialist visit	$50 copay/visit.	Not Covered	
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive, then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay/day for free standing facility/doctor's office, and $150 copay/day for hospital outpatient.	Not Covered	Limit of 1 days of service/year for diagnostic testing, regardless of setting. Technical and professional fees are covered for an unlimited number of tests when provided on the same day.
	Imaging (CT/PET scans, MRIs)	$50 copay/day for free standing facility/doctor's office, and $150 copay/day for hospital outpatient.	Not Covered	Limit of 1 days of service/year for imaging, regardless of setting. Technical and professional fees are covered for an unlimited number of tests when provided on the same day.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Tier 1 drugs	Not Covered	Not Covered	This plan covers certain preventive prescription drugs specified in the health care reform law without cost-sharing. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
	Tier 2 drugs	Not Covered	Not Covered	
	Tier 3 drugs	Not Covered	Not Covered	
	Tier 4 drugs	Not Covered	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
www.flexwork.uhc.com				Members also receive an Optum Perks™ pharmacy discount card that can help save on most FDA-approved medications.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	Not Covered
	Physician/surgeon fees	Not Covered	Not Covered	
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	Not Covered
	Emergency medical transportation	Not Covered	Not Covered	None
	Urgent care	$150 copay/visit includes facility and physician fees.	Not Covered	2 visit limit/year. Lab, x-rays, diagnostic testing and imaging are not included in benefit for urgent care and are subject to applicable benefit for diagnostic testing and imaging.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	Not Covered
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Primary care: $25 copay/visit. Specialist: $50 copay/visit.	Not Covered	4 office visit limit/year, combined sickness, injury, mental health, substance abuse services, pregnancy and specialist visits.
	Inpatient services	Not Covered	Not Covered	Not Covered
If you are pregnant	Office visits	Primary care: $25 copay/visit. Specialist: $50 copay/visit.	Not Covered	4 office visit limit/year, combined sickness, injury, mental health, substance abuse services, pregnancy and specialist visits. Cost sharing does not apply for Health Care Reform preventive services. Maternity care may include tests and services described elsewhere in the SBC

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				(i.e. ultrasound).
	Childbirth/delivery professional services	Not Covered	Not Covered	Not Covered
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	None
	Rehabilitation services	Not Covered	Not Covered	None
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	Not Covered	Not Covered	None
	Durable medical equipment	Not Covered	Not Covered	None
	Hospice services	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Childbirth/Delivery
- Children's eye exam
- Children's dental check-up
- Children's glasses
- Cosmetic surgery
- Dental care (adult)
- Durable medical equipment
- Emergency room care
- Emergency medical transportation
- Habilitation services
- Hearing aids
- Home health care
- Hospice services
- Hospital Stay
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Outpatient Surgery
- Prescription Drugs
- Private-duty nursing
- Rehabilitation services
- Routine eye care (adult)
- Routine foot care
- Skilled nursing care, and
- Weight-loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - 15 visits/year for combined acupuncture and chiropractic visits; $15 copay per visit
- Chiropractic Care - 15 visits/year for combined acupuncture and chiropractic visits; $15 copay per visit

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform . Other coverage

* For more information about limitations and exceptions, see the plan or policy document at www.flexwork.uhc.com.

options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: UnitedHealthcare FlexWork at 1-855-892-2401, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? No

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-291-2634.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-291-2634.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-291-2634.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-291-2634.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$0**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$75
Coinsurance	$0
What isn't covered	
Limits or exclusions	$9,700
The total Peg would pay is	**$9,775**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$0**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,800
The total Joe would pay is	**$5,000**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$0**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,500
The total Mia would pay is	**$2,600**

The plan would be responsible for the other costs of these EXAMPLE covered services.



SUMMARY PLAN DESCRIPTION

ClubCorp USA, Inc. Choice Plus Medical Plans:

Complete Plan with Place of Service Tiering
Complete Plan with UnitedHealth Premium Physician and Place of Service Tiering
Balanced Plan with Place of Service Tiering
Balanced Plan with UnitedHealth Premium Physician and Place of Service Tiering

Effective: January 1, 2022

Group Number: 925871



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Summary Plan Description

United Healthcare Services, Inc.

What Is the Summary Plan Description?

This *Summary Plan Description (SPD)* is a summary of the Covered Health Care Services available to you under the ClubCorp USA, Inc. ("Plan Sponsor") Self-Funded health benefit plan. This *SPD* is a legal document that describes Benefits for the portion of the Plan for which United Healthcare Services, Inc. ("Claims Administrator") administers claims payment, either directly or in conjunction with one of the Claims Administrator's affiliates.

For the purposes of this provision "Self-Funded" means that the Plan Sponsor, on behalf of the Plan, has the sole responsibility to pay, and provide funds, to pay for all Plan benefits. The Claims Administrator has no liability or responsibility to provide these funds. The Claims Administrator is a private healthcare claims administrator. The Claims Administrator is not the Plan Administrator for the Plan. Although the Claims Administrator will assist you in many ways, it does not guarantee any Benefits. The Plan Sponsor is solely responsible for the benefit plan design and funding payment of Benefits.

In addition to this *SPD*, the Plan includes:

- The *Schedule of Benefits.*
- Amendments.
- Addendums.
- Summary Material Modification (SMM).

If there should be an inconsistency between the contents of this summary and the Plan, your rights shall be determined under the Plan and not under this summary. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of the official plan document by written request to the Plan Administrator, for a nominal charge.

Can This SPD Change?

The Plan Sponsor may, from time to time, change this *SPD* by attaching legal documents called SMMs and/or Amendments that may change certain provisions of this *SPD*. When this happens the Plan Sponsor will send you a new *SPD*, SMM or Amendment.

Other Information You Should Have

The Plan Sponsor intends to continue this Plan, but reserves the right, in its sole discretion, to change, interpret, withdraw or add Benefits, or to end the Plan, as permitted by law, without your approval, subject to any collective bargaining agreements, if applicable.

On its effective date, this *SPD* replaces and overrules any *SPD* that the Plan Sponsor may have previously issued to you. This *SPD* will in turn be overruled by any *SPD* issued to you in the future.

The Plan will take effect on the date shown in the Plan. Coverage under the Plan starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Plan Sponsor's location.

The Plan is governed by ERISA unless the Plan Sponsor is not an employee health and welfare plan as defined by ERISA.

Introduction to Your SPD

This *SPD* and the other Plan documents describe your Benefits, as well as your rights and responsibilities, under the Plan.

What Are Defined Terms?

Certain capitalized words have special meanings. The Plan Sponsor has defined these words in *Section 9: Defined Terms.*

When the Plan Sponsor uses the words "you" and "your," the Plan Sponsor is referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms.*

How Do You Use This Document?

Read your entire *SPD* and any attached Summary Material Modifications (SMMs) and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *SPD* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *SPD* at www.myuhc.com.

Review the Benefit limitations of this *SPD* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *SPD* and your Benefits work. Call the Claims Administrator if you have questions about the limits of the coverage available to you.

If there is a conflict between this *SPD* and any summaries provided to you by the Plan Sponsor, this *SPD* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact the Claims Administrator?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact the Claims Administrator for more information.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Plan. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Plan issued to your Plan Sponsor, including the eligibility requirements.
- You must qualify as an Employee or a Dependent as those terms are defined in *Section 9: Defined Terms.*

Your Plan Sponsor may require you to make certain payments to them, in order for you to remain enrolled under the Plan. If you have questions about this, contact your Plan Sponsor.

You may choose to enroll in one of the benefit options from the schedule of benefits. Your choice of benefit option applies to you and to the dependents you enroll for the next calendar year, if you are enrolling during open enrollment. Once you elect a benefit option that election will remain in effect for the calendar year for which it is made unless you have a change in status that permits you to change your election of benefit option. If you have a change in status, that is recognized under this plan, you must notify the plan administrator of the occurrence of such change in status event within 31 days of its occurrence. Please see Special Enrollment Period under Section 3: When Coverage Begins for a discussion of some of the change in status events.

Be Aware the Plan Does Not Pay for All Health Care Services

The Plan does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Physician. The Claims Administrator and the Plan Sponsor do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver your care. The Claims Administrator arranges for Physicians and other health care professionals and facilities to participate in a Network. The Claims Administrator's credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds the Allowed Amount.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Plan's exclusions.

Show Your ID Card

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Plan. You must file the claim in a format that contains all of the information the Claims Administrator requires to process the claim, as described in *Section 5: How to File a Claim.*

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, the Plan will not pay Benefits for health care services for that condition or disability until the prior coverage ends. The Plan will pay Benefits as of the day your coverage begins under the Plan for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage.

Claims Administrator and Plan Sponsor Responsibilities

Determine Benefits

Plan Sponsor and the Claims Administrator make administrative decisions regarding whether the Plan will pay for any portion of the cost of a health care service you intend to receive or have received. Plan Sponsor's and the Claims Administrator's decisions are for payment purposes only. Plan Sponsor and the Claims Administrator do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

Plan Sponsor and the Claims Administrator have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *SPD*, the *Schedule of Benefits* and any SMMs and/or Amendments.
- Make factual determinations relating to Benefits.

Plan Sponsor and the Claims Administrator may assign this discretionary authority to other persons or entities including Claims Administrator’s affiliates that may provide administrative services for the Plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

Process Payment for the Plan's Portion of the Cost of Covered Health Care Services

The Claims Administrator processes the Plan's payment of Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means the Claims Administrator processes only the payment of the Plan's portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Plan.

Process Plan Payment to Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from the Plan. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to the Plan.

Process Plan Payment for Covered Health Care Services Provided by Out-of-Network Providers

The Claims Administrator processes the Plan's payment of Benefits after receiving your request for payment that includes all required information. See *Section 5: How to File a Claim.*

Review and Determine Benefits in Accordance with the Claims Administrator's Reimbursement Policies

The Claims Administrator develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that the Claims Administrator accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), the Claims Administrator's reimbursement policies are applied to provider billings the Claims Administrator shares its reimbursement policies with Physicians and other providers in the Claims Administrator's Network through the Claims Administrator's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by the Claims Administrator's reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts the Plan does not pay, including amounts that are denied because one of the Claims Administrator's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of the Claims Administrator's reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

The Claims Administrator may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, the Claims Administrator will use comparable methodology(ies). The Claims Administrator and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to the Claims Administrator's website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.

Offer Health Education Services to You

The Claims Administrator may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but it is recommended that you discuss them with your Physician.

UnitedHealthcare Choice Plus

United Healthcare Services, Inc.

Schedule of Benefits - Benefit Options You May Elect Each Year

How Do You Access Benefits?

You can choose to receive Designated Network Benefits, Network Benefits or Out-of-Network Benefits.

Designated Network Benefits apply to Covered Health Care Services that are provided by a provider or facility that the Claims Administrator has identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Care Services as shown in the *Schedule of Benefits* table below.

Network Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Care Physician in order to obtain Network Benefits.

Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under Eligible Expenses as described at the end of this section.

Covered Health Services provided at certain Network facilities by a non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under Eligible Expenses as described at the end of this section. For these Covered Health Services, "certain Network facility" is limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under Eligible Expenses as described at the end of this section.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Plan Sponsor, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

The Claims Administrator requires prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call the Claims Administrator at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, ClubCorp USA, Inc. urges you to confirm with the Claims Administrator that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, the Claims Administrator's final coverage determination will be changed to account for those differences, and the Plan will only pay and the Claims Administrator will only process payments for Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Claims Administrator processes payments for Benefits under the Plan), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Claims Administrator will process payments for the Plan as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain prior authorization before receiving Covered Health Care Services.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Limits are calculated on a calendar year basis.

When Benefit limits apply, the limit stated refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Complete Plan with Place of Service Tiering

Payment Term and Description Table

Payment Term And Description	**Amounts**	
Complete Plan with POST	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**
Annual Deductible		
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Care Services under the Plan as indicated in this *Schedule of Benefits*, including covered health care services provided under the *outpatient prescription drug plan*. Allowed Amounts charged by both Network and out-of-Network Providers apply toward both the Network single and family coverage Annual Deductible and the out-of-Network single and family coverage Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a health plan that was replaced by this Plan, any amount already applied to that annual deductible provision of the prior health plan will apply to the Annual Deductible provision under the Plan. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in	$3,000 per Covered Person, not to exceed $8,500 for all Covered Persons in a family.	$3,000 per Covered Person, not to exceed $8,500 for all Covered Persons in a family.

Payment Term And Description	Amounts	
Complete Plan with POST	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**
which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.		
Out-of-Pocket Limit		
The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Plan as indicated in this *Schedule of Benefits*, including covered health care services provided under the *outpatient prescription drug plan*. Allowed Amounts charged by both Network and out-of-Network Providers apply toward both the Network single and family coverage Out-of-Pocket Limit and the out-of-Network single and family coverage Out-of-Pocket Limit. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts or the Recognized Amount when applicable. • Copayments or Coinsurance for any Covered Health Care Service shown in the *Schedule of Benefits* table that does	$7,900 per Covered Person, not to exceed $15,800 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.	$1,000,000 per Covered Person, not to exceed $2,000,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.

Payment Term And Description	Amounts	
Complete Plan with POST	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**
not apply to the Out-of-Pocket Limit. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.		
Copayment		
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.		
Coinsurance		
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.		

Complete Plan with Place of Service Tiering

Schedule of Benefits Table

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 9: *Defined Terms*. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Ambulance Services			
Prior Authorization Requirement In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain prior authorization as soon as possible before transport.			
Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 30% *Air Ambulance:* 30%	Same as Network	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	
Does the Annual Deductible Apply?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Non-Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 30% *Air Ambulance:* 30%	Same as Network	Ground or Air Ambulance, as the Claims Administrator determines appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	*Ground Ambulance:* Yes *Air Ambulance:* Yes	
Does the Annual Deductible Apply?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	*Ground Ambulance:* Yes *Air Ambulance:* Yes	
Cellular and Gene Therapy			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Out-of-Network Benefits are not available.	For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Clinical Trials			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.
Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement For Out-of-Network, you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. **It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Dental Services - Accident Only			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	Same as Network	Limited to $3,000 per year. Benefits are further limited to a maximum of $900 per tooth.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Same as Network	
Does the Annual Deductible Apply?	Yes	Same as Network	
Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Diabetes Self-Management Items	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	
Does the Annual Deductible Apply?	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	
Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	To receive Network Benefits, you must purchase, rent or obtain the DME from the vendor the Claims Administrator identifies or purchase it directly from the prescribing Network Physician.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Emergency Health Care Services - Outpatient			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$500 per visit	Same as Network	**Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Copayment, Coinsurance and/or deductible. This does not apply to services provided to stabilize an Emergency after admission to a Hospital.

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Same as Network	This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Annual Deductible Apply?	No	Same as Network	
Enteral Nutrition			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Same as Network	
Does the Annual Deductible Apply?	Yes	Same as Network	
Gender Dysphoria			
Prior Authorization Requirement for Surgical Treatment For Non-Network Benefits you must obtain prior authorization as soon as the possibility of surgery arises. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay. **Prior Authorization Requirement for Non-Surgical Treatment** Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.			

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Habilitative Services			
Inpatient	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Primary Care* Physician $20 per visit *Specialist* $50	50%	Outpatient therapies: • Physical therapy. • Occupational therapy including Cognitive therapy. • Manipulative Treatment. • Speech therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	No	Yes	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Limited to 30 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30% *Inpatient Facility/Birthing Center facility charges for delivery* None for Inpatient Facility/Birthing Center facility charges only all other services covered at 30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes, except facility charges for delivery	Yes	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Lab, X-Ray and Diagnostic - Minor Outpatient Services			
Prior Authorization Requirement For Out-of-Network Benefits for sleep studies, you must obtain prior authorization five business days before scheduled services are received.			
Lab Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding lab, Ambulatory surgical center or in a Physician's office* **None** at a freestanding lab, ambulatory surgical center or in a Physician's office *Hospital-based lab* 40% *Inpatient Professional* 30% *Outpatient Professional* 40%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Hospital-based lab* Yes *Inpatient Professional* Yes *Outpatient Professional* Yes	Yes	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Hospital-based lab* Yes *Inpatient Professional* Yes *Outpatient Professional* Yes	Yes	
X-Ray and Other Diagnostic Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding diagnostic center, Ambulatory surgical center or in a Physician's office* **None** at a *Freestanding diagnostic center*, ambulatory surgical center or in a Physician's office *Outpatient Hospital-based diagnostic center* 40% at an outpatient Hospital-based diagnostic center or outpatient facility *Inpatient Professional* 30% *Outpatient Professional* 40%	50%	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Outpatient Hospital-based diagnostic center or Outpatient Facility* Yes *Inpatient Professional* Yes *Outpatient Professional* Yes	Yes	
Does the Annual Deductible Apply?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Outpatient Hospital-based diagnostic center or Outpatient Facility* Yes *Inpatient Professional* Yes *Outpatient Professional* Yes	Yes	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Major Diagnostic and Imaging - Outpatient			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding diagnostic center, Ambulatory surgical center* None at a freestanding diagnostic center or ambulatory surgical center *Physician's office* $20 per visit *Outpatient Hospital-based diagnostic center* 40% *Outpatient facility* $400 per service at an outpatient facility *Outpatient Professional* 40%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding diagnostic center, Ambulatory surgical center* No *Physician's office* No *Outpatient Hospital-based diagnostic center* Yes *Outpatient Facility* Yes *Outpatient Professional* Yes	Yes	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	*Freestanding diagnostic center, Ambulatory surgical center* No *Physician's office* No *Outpatient Hospital-based diagnostic center* Yes *Outpatient Facility* Yes *Outpatient Professional* Yes	Yes	
Mental Health Care and Substance-Related and Addictive Disorders Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility and Partial Hospitalization/Day Treatment) you must obtain prior authorization five business days before admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Out-of-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management.			
Inpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Limited to 30 days per calendar year

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$20 per visit	50%	Limited to 30 days per calendar year
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	No	Yes	
Virtual Behavioral Health Therapy and Coaching What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** *AbleTo* None	Out-of-Network Benefits are not available.	There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Obesity – Weight Loss Surgery			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*	Out-of-Network Benefits are not available.	Benefits are limited to one procedure during the entire period of time a Covered Person is enrolled under the Plan.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	Yes	Out-of-Network Benefits are not available.	
Ostomy Supplies			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Pharmaceutical Products - Outpatient			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Physician Fees for Surgical and Medical Services			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$20 per visit for a Primary Care Physician office visit or $50 per visit for a Specialist office visit Inpatient/Outpatient Professional 30%	50%	Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes *Inpatient/Outpatient Professional* Yes	Yes	
Does the Annual Deductible Apply?	No *Inpatient/Outpatient Professional* Yes	Yes	
Physician's Office Services - Sickness and Injury			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$20 per visit for a Primary Care Physician office visit or $50 per visit for a Specialist office visit	50%	Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and*

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
			Diagnostics - Outpatient. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*. • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy* and *Manipulative Treatment*. • Habilitative therapy services described under *Habilitative Services*.

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	No	Yes	
Pregnancy - Maternity Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. **It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.**			
	Global Delivery Fee/Facility Fee Delivery fees are covered 100%, no Annual Deductible) when performed by a Network provider regardless of place of service (i.e., home, hospital or birthing facility (No coverage for Doulas). An Annual Deductible will also not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. *All other services outside of the Global Delivery fee/facility fee* Benefits will be the same as those stated under each Covered Health Care Service category in this	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
	Schedule of Benefits		
Preventive Care Services			
Physician office services What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	
Lab, X-ray or other preventive tests What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Breast pumps What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	
Prosthetic Devices			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$20 per visit for a Primary Care Physician office visit or $50 per visit for a Specialist office visit	50%	Limited per year as follows: • 30 visits of physical therapy. • 30 visits of occupational therapy. • 30 visits of speech therapy. • Unlimited visits of pulmonary therapy. • Unlimited visits of cardiac therapy. • Unlimited visits of Manipulative Treatments.

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	No	Yes	
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Limited to 25 days per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	Yes	Yes	
Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for Genetic Testing and sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** *Freestanding facility, Ambulatory surgical center or in a Physician's office* $200 per date of service at an ambulatory surgical center or in a Physician's office ***Network*** *Outpatient Hospital-based surgical center* $400 per date of service at an outpatient Hospital-based surgical center	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding facility, Ambulatory surgical center or in a Physician's office* Yes *Outpatient Hospital-based surgical center* Yes	*Freestanding facility, Ambulatory surgical center or in a Physician's office* Yes *Outpatient Hospital-based surgical center* Yes	

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	*Freestanding facility, Ambulatory surgical center or in a Physician's office* No *Outpatient Hospital-based surgical center* No	*Freestanding facility, Ambulatory surgical center or in a Physician's office* Yes *Outpatient Hospital-based surgical center* Yes	
Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Transplantation Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	For Network Benefits, transplantation services must be received from a Designated Provider. The Claims Administrator does not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.
Urgent Care Center Services			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$75 per visit	50%	In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
			procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	No	Yes	
Urinary Catheters			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Virtual Care Services			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your

Complete Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
			ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	
Wigs			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	30%	Limited to $500 per lifetime.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Complete Plan with UnitedHealth Premium Physician and Place of Service Tiering

Payment Term and Description Table

Payment Term And Description	Amounts	
Complete Plan with UHPD and POST	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**
Annual Deductible		
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Care Services under the Plan as indicated in this *Schedule of Benefits*, including covered health care services provided under the *outpatient prescription drug plan*. Allowed Amounts charged by both Network and out-of-Network Providers apply toward both the Network single and family coverage Annual Deductible and the out-of-Network single and family coverage Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a health plan that was replaced by this Plan, any amount already applied to that annual deductible provision of the prior health plan will apply to the Annual Deductible provision under the Plan. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	$3,000 per Covered Person, not to exceed $8,500 for all Covered Persons in a family.	$3,000 per Covered Person, not to exceed $8,500 for all Covered Persons in a family.

Payment Term And Description	Amounts	
Complete Plan with UHPD and POST	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**
Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.		
Out-of-Pocket Limit		
The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Plan as indicated in this *Schedule of Benefits*, including covered health care services provided under the *outpatient prescription drug plan*. Allowed Amounts charged by both Network and out-of-Network Providers apply toward both the Network single and family coverage Out-of-Pocket Limit and the out-of-Network single and family coverage Out-of-Pocket Limit. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts or the Recognized Amount when applicable. • Copayments or Coinsurance for any Covered Health Care Service shown in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Limit.	$7,900 per Covered Person, not to exceed $15,800 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.	$1,000,000 per Covered Person, not to exceed $2,000,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.

Payment Term And Description	Amounts	
Complete Plan with UHPD and POST	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**
Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.		
Copayment		
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.		
Coinsurance		
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.		

Complete Plan with UnitedHealth Premium Physician and Place of Service Tiering

Schedule of Benefits Table

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 9: *Defined Terms*. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Ambulance Services			
Prior Authorization Requirement In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain prior authorization as soon as possible before transport.			
Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 30% *Air Ambulance:* 30%	Same as Network	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	
Does the Annual Deductible Apply?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Non-Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 30% *Air Ambulance:* 30%	Same as Network	Ground or Air Ambulance, as the Claims Administrator determines appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	*Ground Ambulance:* Yes *Air Ambulance:* Yes	
Does the Annual Deductible Apply?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	*Ground Ambulance:* Yes *Air Ambulance:* Yes	
Cellular and Gene Therapy			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Out-of-Network Benefits are not available.	For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Clinical Trials			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.
Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement For Out-of-Network, you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. **It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Dental Services - Accident Only			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	Same as Network	Limited to $3,000 per year. Benefits are further limited to a maximum of $900 per tooth.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Same as Network	
Does the Annual Deductible Apply?	Yes	Same as Network	
Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Diabetes Self-Management Items	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
	outpatient prescription drug plan.	*outpatient prescription drug plan*.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	
Does the Annual Deductible Apply?	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	
Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	To receive Network Benefits, you must purchase, rent or obtain the DME from the vendor the Claims Administrator identifies or purchase it directly from the prescribing Network Physician.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	Yes	Yes	
Emergency Health Care Services - Outpatient			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$500 per visit	Same as Network	**Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Copayment, Coinsurance and/or deductible. This does not apply to services provided to stabilize an Emergency after admission to a Hospital.

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Same as Network	This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Annual Deductible Apply?	No	Same as Network	
Enteral Nutrition			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Same as Network	
Does the Annual Deductible Apply?	Yes	Same as Network	
Gender Dysphoria			
Prior Authorization Requirement for Surgical Treatment For Non-Network Benefits you must obtain prior authorization as soon as the possibility of surgery arises. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay.			

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Prior Authorization Requirement for Non-Surgical Treatment Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Habilitative Services			
Inpatient	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Primary Care* Physician $20 per visit *Specialist* $50	50%	Outpatient therapies: • Physical therapy. • Occupational therapy including Cognitive therapy. • Manipulative Treatment. • Speech therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment*.

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	No	Yes	
Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Limited to 30 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.			

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30% *Inpatient Facility/Birthing Center facility charges for delivery* None for Inpatient Facility/Birthing Center facility charges only all other services covered at 30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes, except facility charges for delivery	Yes	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Lab, X-Ray and Diagnostic - Minor Outpatient Services			
Prior Authorization Requirement For Out-of-Network Benefits for sleep studies, you must obtain prior authorization five business days before scheduled services are received.			
Lab Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding lab, Ambulatory surgical center or in a Physician's office* **None** at a freestanding lab, ambulatory surgical center or in a Physician's office *Hospital-based lab* 40% *Inpatient Professional* 30% *Outpatient Professional* 40%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Hospital-based lab* Yes *Inpatient Professional* Yes *Outpatient Professional* Yes	Yes	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Hospital-based lab* Yes *Inpatient Professional* Yes *Outpatient Professional* Yes	Yes	
X-Ray and Other Diagnostic Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding diagnostic center, Ambulatory surgical center or in a Physician's office* **None** at a *Freestanding diagnostic center*, ambulatory surgical center or in a Physician's office *Outpatient Hospital-based diagnostic center* 40% at an outpatient Hospital-based diagnostic center or outpatient facility *Inpatient Professional* 30% *Outpatient Professional* 40%	50%	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Outpatient Hospital-based diagnostic center or Outpatient Facility* Yes *Inpatient Professional* Yes *Outpatient Professional* Yes	Yes	
Does the Annual Deductible Apply?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Outpatient Hospital-based diagnostic center or Outpatient Facility* Yes *Inpatient Professional* Yes *Outpatient Professional* Yes	Yes	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Major Diagnostic and Imaging - Outpatient			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding diagnostic center, Ambulatory surgical center* None at a freestanding diagnostic center or ambulatory surgical center *Physician's office* $20 per visit *Outpatient Hospital-based diagnostic center* 40% *Outpatient facility* $400 per service at an outpatient facility *Outpatient Professional* 40%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding diagnostic center, Ambulatory surgical center* No *Physician's office* No *Outpatient Hospital-based diagnostic center* Yes *Outpatient Facility* Yes *Outpatient Professional* Yes	Yes	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	*Freestanding diagnostic center, Ambulatory surgical center* No *Physician's office* No *Outpatient Hospital-based diagnostic center* Yes *Outpatient Facility* Yes *Outpatient Professional* Yes	Yes	
Mental Health Care and Substance-Related and Addictive Disorders Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility and Partial Hospitalization/Day Treatment) you must obtain prior authorization five business days before admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Out-of-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management.			
Inpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Limited to 30 days per calendar year

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$20 per visit	50%	Limited to 30 days per calendar year
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	No	Yes	
Virtual Behavioral Health Therapy and Coaching What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** *AbleTo* None	Out-of-Network Benefits are not available.	There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Obesity – Weight Loss Surgery			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*	Out-of-Network Benefits are not available.	Benefits are limited to one procedure during the entire period of time a Covered Person is enrolled under the Plan.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	Yes	Out-of-Network Benefits are not available.	
Ostomy Supplies			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Pharmaceutical Products - Outpatient			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Physician Fees for Surgical and Medical Services			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** $20 per visit for a Primary Care Physician office visit or $50 per visit for a Specialist office visit ***Network*** $40 per visit for a Primary Care Physician office visit or $70 per visit for a Specialist office visit Inpatient/Outpatient Professional 30%	50%	Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** Yes ***Network*** Yes *Inpatient/Outpatient Professional* Yes	Yes	
Does the Annual Deductible Apply?	***Designated Network*** No ***Network*** No *Inpatient/Outpatient Professional* Yes	Yes	
Physician's Office Services - Sickness and Injury			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** $20 per visit for a Primary Care Physician office visit or $50 per visit for a Specialist office visit ***Network*** $40 per visit for a Primary Care Physician office visit or $70 per visit for a Specialist office visit	50%	Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
			therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*. • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy* and *Manipulative Treatment*. • Habilitative therapy services described under *Habilitative Services*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** Yes ***Network*** Yes	Yes	
Does the Annual Deductible Apply?	***Designated Network*** No ***Network*** No	Yes	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Pregnancy - Maternity Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. **It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.**			
	Global Delivery Fee/Facility Fee Delivery fees are covered 100%, no Annual Deductible) when performed by a Network provider regardless of place of service (i.e., home, hospital or birthing facility (No coverage for Doulas). An Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. *All other services outside of the Global Delivery fee/facility fee* Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Example: Home birth not covered by a Doula - but if done by Network OBGYN, then covered at 100%, no Annual Deductible.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	Yes, except facility charges for delivery	Yes	
Preventive Care Services			
Physician office services What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	
Lab, X-ray or other preventive tests What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Breast pumps What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	
Prosthetic Devices			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$20 per visit for a Primary Care Physician office visit or $50 per visit for a Specialist office visit	50%	Limited per year as follows: • 30 visits of physical therapy. • 30 visits of occupational therapy. • 30 visits of speech therapy. • Unlimited visits of pulmonary therapy. • Unlimited visits of cardiac therapy. • Unlimited visits of Manipulative Treatments.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	No	Yes	
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Limited to 25 days per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** *Freestanding facility, Ambulatory surgical center or in a Physician's office* $200 per date of service at an ambulatory surgical center or in a Physician's office ***Network*** *Outpatient Hospital-based surgical center* $400 per date of service at an outpatient Hospital-based surgical center	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding facility, Ambulatory surgical center or in a Physician's office* Yes *Outpatient Hospital-based surgical center* Yes	*Freestanding facility, Ambulatory surgical center or in a Physician's office* Yes *Outpatient Hospital-based surgical center* Yes	
Does the Annual Deductible Apply?	*Freestanding facility, Ambulatory surgical center or in a Physician's office* No *Outpatient Hospital-based surgical center* No	*Freestanding facility, Ambulatory surgical center or in a Physician's office* Yes *Outpatient Hospital-based surgical center* Yes	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Transplantation Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	For Network Benefits, transplantation services must be received from a Designated Provider. The Claims Administrator does not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Urgent Care Center Services			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$75 per visit	50%	In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	No	Yes	
Urinary Catheters			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Virtual Care Services			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Out-of-Network Benefits are not available.	

Complete Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	
Wigs			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	30%	Limited to $500 per lifetime.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Balanced Plan with Place of Service Tiering

Payment Term and Description Table

Payment Term And Description	Amounts	
Balanced Plan with POST	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**
Annual Deductible		
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Care Services under the Plan as indicated in this *Schedule of Benefits*, including covered health care services provided under the outpatient prescription drug plan. Allowed Amounts charged by both Network and out-of-Network Providers apply toward both the Network single and family coverage Annual Deductible and the out-of-Network single and family coverage Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a health plan that was replaced by this Plan, any amount already applied to that annual deductible provision of the prior health plan will apply to the Annual Deductible provision under the Plan. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your	$5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family.	$5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family.

Payment Term And Description	Amounts	
Balanced Plan with POST	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**
Annual Deductible.		
Out-of-Pocket Limit		
The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Plan as indicated in this *Schedule of Benefits*, including covered health care services provided under the *outpatient prescription drug plan*. Allowed Amounts charged by both Network and out-of-Network Providers apply toward both the Network single and family coverage Out-of-Pocket Limit and the out-of-Network single and family coverage Out-of-Pocket Limit. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts or the Recognized Amount when applicable. • Copayments or Coinsurance for any Covered Health Care Service shown in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Limit. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	$8,500 per Covered Person~~, not to exceed $Unlimited for all Covered Persons in a family~~. Each Covered Person's Out-of-Pocket Limit must be met before individual family member qualifies for post Out-of-Pocket coverage at 100% The Out-of-Pocket Limit includes the Annual Deductible.	$1,000,000 per Covered Person, not to exceed $2,000,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.

Payment Term And Description	Amounts	
Balanced Plan with POST	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**
Copayment		
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.		
Coinsurance		
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.		

Balanced Plan with Place of Service Tiering

Schedule of Benefits Table

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 9: *Defined Terms*. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Ambulance Services			
Prior Authorization Requirement In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain prior authorization as soon as possible before transport.			
Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 30% *Air Ambulance:* 30%	Same as Network	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	
Does the Annual Deductible Apply?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Non-Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 30% *Air Ambulance:* 30%	Same as Network	Ground or Air Ambulance, as the Claims Administrator determines appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	*Ground Ambulance:* Yes *Air Ambulance:* Yes	
Does the Annual Deductible Apply?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	*Ground Ambulance:* Yes *Air Ambulance:* Yes	
Cellular and Gene Therapy			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Out-of-Network Benefits are not available.	For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Clinical Trials			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.
Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement For Out-of-Network, you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. **It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Dental Services - Accident Only			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	Same as Network	Limited to $3,000 per year. Benefits are further limited to a maximum of $900 per tooth.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Same as Network	
Does the Annual Deductible Apply?	Yes	Same as Network	
Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Diabetes Self-Management Items	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient*	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient*	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
	prescription drug plan.	*prescription drug plan*.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	
Does the Annual Deductible Apply?	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	
Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	To receive Network Benefits, you must purchase, rent or obtain the DME from the vendor the Claims Administrator identifies or purchase it directly from the prescribing Network Physician.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual	Yes	Yes	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Deductible Apply?			
Emergency Health Care Services - Outpatient			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$500 per visit	Same as Network	**Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Copayment, Coinsurance and/or deductible. This does not apply to services provided to stabilize an Emergency after admission to a Hospital.

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Same as Network	This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Annual Deductible Apply?	No	Same as Network	
Enteral Nutrition			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Same as Network	
Does the Annual Deductible Apply?	Yes	Same as Network	
Gender Dysphoria			
Prior Authorization Requirement for Surgical Treatment For Non-Network Benefits you must obtain prior authorization as soon as the possibility of surgery arises. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay. **Prior Authorization Requirement for Non-Surgical Treatment** Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in			

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
this *Schedule of Benefits*.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Habilitative Services			
Inpatient	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Primary Care* Physician $30 per visit *Specialist* $60	50%	Outpatient therapies: • Physical therapy. • Occupational therapy including Cognitive therapy. • Manipulative Treatment. • Speech therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual	No	Yes	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Deductible Apply?			
Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Limited to 30 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30% *Inpatient Facility/Birthing Center facility charges for delivery* None for Inpatient Facility/Birthing Center facility charges only all other services covered at 30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes, except facility charges for delivery	Yes	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Lab, X-Ray and Diagnostic - Minor Outpatient Services			
Prior Authorization Requirement For Out-of-Network Benefits for sleep studies, you must obtain prior authorization five business days before scheduled services are received.			
Lab Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding lab, Ambulatory surgical center or in a Physician's office* **None** at a freestanding lab, ambulatory surgical center or in a Physician's office *Hospital-based lab* 40% *Inpatient Professional* 30% *Outpatient Professional* 40%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Hospital-based lab* Yes *Inpatient Professional* Yes *Outpatient Professional* Yes	Yes	
Does the Annual Deductible Apply?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Hospital-based lab*	Yes	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
	Yes *Inpatient Professional* Yes *Outpatient Professional* Yes		
X-Ray and Other Diagnostic Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding diagnostic center, Ambulatory surgical center or in a Physician's office* **None** at a *Freestanding diagnostic center*, ambulatory surgical center or in a Physician's office *Outpatient Hospital-based diagnostic center* 40% at an outpatient Hospital-based diagnostic center or outpatient facility *Inpatient Professional* 30% *Outpatient Professional* 40%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Outpatient Hospital-based diagnostic center or Outpatient Facility* Yes *Inpatient Professional*	Yes	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
	Yes *Outpatient Professional* Yes		
Does the Annual Deductible Apply?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Outpatient Hospital-based diagnostic center or Outpatient Facility* Yes *Inpatient Professional* Yes *Outpatient Professional* Yes	Yes	
Major Diagnostic and Imaging - Outpatient			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding diagnostic center, Ambulatory surgical center* None at a freestanding diagnostic center or ambulatory surgical center *Physician's office* $30 per visit *Outpatient Hospital-based diagnostic center* 40% *Outpatient facility* $400 per service at an outpatient facility	50%	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
	Outpatient Professional 40%		
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding diagnostic center, Ambulatory surgical center* No *Physician's office* No *Outpatient Hospital-based diagnostic center* Yes *Outpatient Facility* Yes *Outpatient Professional* Yes	Yes	
Does the Annual Deductible Apply?	*Freestanding diagnostic center, Ambulatory surgical center* No *Physician's office* No *Outpatient Hospital-based diagnostic center* Yes *Outpatient Facility* Yes *Outpatient Professional* Yes	Yes	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Mental Health Care and Substance-Related and Addictive Disorders Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility and Partial Hospitalization/Day Treatment) you must obtain prior authorization five business days before admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Out-of-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management.			
Inpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Limited to 30 days per calendar year
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$30 per visit	50%	Limited to 30 days per calendar year
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	No	Yes	
Virtual Behavioral Health Therapy and Coaching What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** *AbleTo* None	Out-of-Network Benefits are not available.	There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	
Obesity – Weight Loss Surgery			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*	Out-of-Network Benefits are not available.	Benefits are limited to one procedure during the entire period of time a Covered Person is enrolled under the Plan.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	Yes	Out-of-Network Benefits are not available.	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Ostomy Supplies			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Pharmaceutical Products - Outpatient			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Physician Fees for Surgical and Medical Services			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$30 per visit for a Primary Care Physician office visit or $60 per visit for a Specialist office visit Inpatient/Outpatient Professional 30%	50%	Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however Allowed Amounts will be determined

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
			as described below under Allowed Amounts in this Schedule of Benefits.
Does the Amount You Pay Apply to the Out-of-Pocket Limit? Does the Annual Deductible Apply?	Yes *Inpatient/Outpatient Professional* Yes No *Inpatient/Outpatient Professional* Yes	Yes Yes	
Physician's Office Services - Sickness and Injury			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$30 per visit for a Primary Care Physician office visit or $60 per visit for a Specialist office visit	50%	Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
			• Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*. • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy* and *Manipulative Treatment*. • Habilitative therapy services described under *Habilitative Services*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	No	Yes	
Pregnancy - Maternity Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. **It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.**			
	Global Delivery Fee/Facility Fee Delivery fees are covered 100%, no Annual Deductible)	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
	when performed by a Network provider regardless of place of service (i.e., home, hospital or birthing facility (No coverage for Doulas). An Annual Deductible will also not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. *All other services outside of the Global Delivery fee/facility fee* Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*	except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Preventive Care Services			
Physician office services What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Lab, X-ray or other preventive tests What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	
Breast pumps What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Prosthetic Devices			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$30 per visit for a Primary Care Physician office visit or $60 per visit for a Specialist office visit	50%	Limited per year as follows: • 30 visits of physical therapy. • 30 visits of occupational therapy. • 30 visits of speech therapy. • Unlimited visits of pulmonary therapy. • Unlimited visits of cardiac therapy. • Unlimited visits of Manipulative Treatments.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	No	Yes	
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Limited to 25 days per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** *Freestanding facility, Ambulatory surgical center or in a Physician's office* $300 per date of service at an ambulatory surgical center or in a Physician's office ***Network*** *Outpatient Hospital-based surgical center*	50%	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
	$400 per date of service at an outpatient Hospital-based surgical center		
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding facility, Ambulatory surgical center or in a Physician's office* Yes *Outpatient Hospital-based surgical center* Yes	*Freestanding facility, Ambulatory surgical center or in a Physician's office* Yes *Outpatient Hospital-based surgical center* Yes	
Does the Annual Deductible Apply?	*Freestanding facility, Ambulatory surgical center or in a Physician's office* No *Outpatient Hospital-based surgical center* No	*Freestanding facility, Ambulatory surgical center or in a Physician's office* Yes *Outpatient Hospital-based surgical center* Yes	
Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	Yes	Yes	
Transplantation Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	For Network Benefits, transplantation services must be received from a Designated Provider. The Claims Administrator does not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.
Urgent Care Center Services			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$100 per visit	50%	In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*.

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
			• Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	No	Yes	
Urinary Catheters			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Balanced Plan with POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Virtual Care Services			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	
Wigs			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	30%	Limited to $500 per lifetime.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Balanced Plan with UnitedHealth Premium Physician and Place of Service Tiering
Payment Term and Description Table

Payment Term And Description	Amounts	
Balanced Plan with UHPD and POST	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**
Annual Deductible		
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Care Services under the Plan as indicated in this *Schedule of Benefits*, including covered health care services provided under the *outpatient prescription drug plan*. Allowed Amounts charged by both Network and out-of-Network Providers apply toward both the Network single and family coverage Annual Deductible and the out-of-Network single and family coverage Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a health plan that was replaced by this Plan, any amount already applied to that annual deductible provision of the prior health plan will apply to the Annual Deductible provision under the Plan. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.	$5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family.	$5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family.

Payment Term And Description	Amounts	
Balanced Plan with UHPD and POST	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**
Out-of-Pocket Limit		
The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Plan as indicated in this *Schedule of Benefits*, including covered health care services provided under the *outpatient prescription drug plan*. Allowed Amounts charged by both Network and out-of-Network Providers apply toward both the Network single and family coverage Out-of-Pocket Limit and the out-of-Network single and family coverage Out-of-Pocket Limit. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts or the Recognized Amount when applicable. • Copayments or Coinsurance for any Covered Health Care Service shown in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Limit. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	$8,500 per Covered Person.~~,~~ Each Covered Person's Out-of-Pocket Limit must be met before individual family member qualifies for post Out-of-Pocket coverage at 100%~~not to exceed $Unlimited for all Covered Persons in a family~~. The Out-of-Pocket Limit includes the Annual Deductible.	$1,000,000 per Covered Person, not to exceed $2,000,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.

Payment Term And Description	Amounts	
Balanced Plan with UHPD and POST	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**
Copayment		
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.		
Coinsurance		
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.		

Balanced Plan with UnitedHealth Premium Physician and Place of Service Tiering

Schedule of Benefits Table

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 9: *Defined Terms*. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Ambulance Services			
Prior Authorization Requirement In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain prior authorization as soon as possible before transport.			
Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 30% *Air Ambulance:* 30%	Same as Network	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	
Does the Annual Deductible Apply?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	Same as Network	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Non-Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 30% *Air Ambulance:* 30%	Same as Network	Ground or Air Ambulance, as the Claims Administrator determines appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	*Ground Ambulance:* Yes *Air Ambulance:* Yes	
Does the Annual Deductible Apply?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	*Ground Ambulance:* Yes *Air Ambulance:* Yes	
Cellular and Gene Therapy			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Out-of-Network Benefits are not available.	For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Clinical Trials			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.
Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement For Out-of-Network, you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. **It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Dental Services - Accident Only			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	Same as Network	Limited to $3,000 per year. Benefits are further limited to a maximum of $900 per tooth.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Same as Network	
Does the Annual Deductible Apply?	Yes	Same as Network	
Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Diabetes Self-Management Items	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
	outpatient prescription drug plan.	*outpatient prescription drug plan*.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	
Does the Annual Deductible Apply?	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *outpatient prescription drug plan*.	
Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	To receive Network Benefits, you must purchase, rent or obtain the DME from the vendor the Claims Administrator identifies or purchase it directly from the prescribing Network Physician.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	Yes	Yes	
Emergency Health Care Services - Outpatient			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$500 per visit	Same as Network	**Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Copayment, Coinsurance and/or deductible. This does not apply to services provided to stabilize an Emergency after admission to a Hospital.

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Same as Network	This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Annual Deductible Apply?	No	Same as Network	
Enteral Nutrition			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Same as Network	
Does the Annual Deductible Apply?	Yes	Same as Network	
Gender Dysphoria			
Prior Authorization Requirement for Surgical Treatment For Non-Network Benefits you must obtain prior authorization as soon as the possibility of surgery arises. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay. **Prior Authorization Requirement for Non-Surgical Treatment** Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in			

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
this *Schedule of Benefits*.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Habilitative Services			
Inpatient	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Primary Care* Physician $30 per visit *Specialist* $60	50%	Outpatient therapies: • Physical therapy. • Occupational therapy including Cognitive therapy. • Manipulative Treatment. • Speech therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	No	Yes	
Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Limited to 30 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.			

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30% *Inpatient Facility/Birthing Center facility charges for delivery* None for Inpatient Facility/Birthing Center facility charges only all other services covered at 30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes, except facility charges for delivery	Yes	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Lab, X-Ray and Diagnostic - Minor Outpatient Services			
Prior Authorization Requirement For Out-of-Network Benefits for sleep studies, you must obtain prior authorization five business days before scheduled services are received.			
Lab Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding lab, Ambulatory surgical center or in a Physician's office* **None** at a freestanding lab, ambulatory surgical center or in a Physician's office *Hospital-based lab* 40% *Inpatient Professional* 30% *Outpatient Professional* 40%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Hospital-based lab* Yes *Inpatient Professional* Yes *Outpatient Professional* Yes	Yes	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Hospital-based lab* Yes *Inpatient Professional* Yes *Outpatient Professional* Yes	Yes	
X-Ray and Other Diagnostic Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding diagnostic center, Ambulatory surgical center or in a Physician's office* **None** at a *Freestanding diagnostic center*, ambulatory surgical center or in a Physician's office *Outpatient Hospital-based diagnostic center* 40% at an outpatient Hospital-based diagnostic center or outpatient facility *Inpatient Professional* 30% *Outpatient Professional* 40%	50%	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Outpatient Hospital-based diagnostic center or Outpatient Facility* Yes *Inpatient Professional* Yes *Outpatient Professional* Yes	Yes	
Does the Annual Deductible Apply?	*Freestanding lab, Ambulatory surgical center or in a Physician's office* No *Outpatient Hospital-based diagnostic center or Outpatient Facility* Yes *Inpatient Professional* Yes *Outpatient Professional* Yes	Yes	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Major Diagnostic and Imaging - Outpatient			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Freestanding diagnostic center, Ambulatory surgical center* None at a freestanding diagnostic center or ambulatory surgical center *Physician's office* $30 per visit *Outpatient Hospital-based diagnostic center* 40% *Outpatient facility* $400 per service at an outpatient facility *Outpatient Professional* 40%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding diagnostic center, Ambulatory surgical center* No *Physician's office* No *Outpatient Hospital-based diagnostic center* Yes *Outpatient Facility* Yes *Outpatient Professional* Yes	Yes	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	*Freestanding diagnostic center, Ambulatory surgical center* No *Physician's office* No *Outpatient Hospital-based diagnostic center* Yes *Outpatient Facility* Yes *Outpatient Professional* Yes	Yes	
Mental Health Care and Substance-Related and Addictive Disorders Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility and Partial Hospitalization/Day Treatment) you must obtain prior authorization five business days before admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Out-of-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management.			
Inpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Limited to 30 days per calendar year

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$30 per visit	50%	Limited to 30 days per calendar year
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	No	Yes	
Virtual Behavioral Health Therapy and Coaching What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** *AbleTo* None	Out-of-Network Benefits are not available.	There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Obesity – Weight Loss Surgery			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*	Out-of-Network Benefits are not available.	Benefits are limited to one procedure during the entire period of time a Covered Person is enrolled under the Plan.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	Yes	Out-of-Network Benefits are not available.	
Ostomy Supplies			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Pharmaceutical Products - Outpatient			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Physician Fees for Surgical and Medical Services			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** $30 per visit for a Primary Care Physician office visit or $60 per visit for a Specialist office visit ***Network*** $50 per visit for a Primary Care Physician office visit or $80 per visit for a Specialist office visit Inpatient/Outpatient Professional 30%	50%	Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** Yes ***Network*** Yes *Inpatient/Outpatient Professional* Yes	Yes	
Does the Annual Deductible Apply?	***Designated Network*** No ***Network*** No *Inpatient/Outpatient Professional* Yes	Yes	
Physician's Office Services - Sickness and Injury			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** $30 per visit for a Primary Care Physician office visit or $60 per visit for a Specialist office visit ***Network*** $50 per visit for a Primary Care Physician office visit or $80 per visit for a Specialist office visit	50%	Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
			therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*. • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy* and *Manipulative Treatment*. • Habilitative therapy services described under *Habilitative Services*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit? Does the Annual Deductible Apply?	***Designated Network*** Yes ***Network*** Yes ***Designated Network*** No ***Network*** No	Yes Yes	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Pregnancy - Maternity Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. **It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.**			
	Global Delivery Fee/Facility Fee Delivery fees are covered 100%, no Annual Deductible) when performed by a Network provider regardless of place of service (i.e., home, hospital or birthing facility (No coverage for Doulas). An Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. *All other services outside of the Global Delivery fee/facility fee* Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Example: Home birth not covered by a Doula - but if done by Network OBGYN, then covered at 100%, no Annual Deductible.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	Yes, except facility charges for delivery	Yes	
Preventive Care Services			
Physician office services What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	
Lab, X-ray or other preventive tests What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Breast pumps What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	
Prosthetic Devices			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$30 per visit for a Primary Care Physician office visit or $60 per visit for a Specialist office visit	50%	Limited per year as follows: • 30 visits of physical therapy. • 30 visits of occupational therapy. • 30 visits of speech therapy. • Unlimited visits of pulmonary therapy. • Unlimited visits of cardiac therapy. • Unlimited visits of Manipulative Treatments.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Annual Deductible Apply?	No	Yes	
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	Limited to 25 days per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** *Freestanding facility, Ambulatory surgical center or in a Physician's office* $300 per date of service at an ambulatory surgical center or in a Physician's office ***Network*** *Outpatient Hospital-based surgical center* $400 per date of service at an outpatient Hospital-based surgical center	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Freestanding facility, Ambulatory surgical center or in a Physician's office* Yes *Outpatient Hospital-based surgical center* Yes	*Freestanding facility, Ambulatory surgical center or in a Physician's office* Yes *Outpatient Hospital-based surgical center* Yes	
Does the Annual Deductible Apply?	*Freestanding facility, Ambulatory surgical center or in a Physician's office* No *Outpatient Hospital-based surgical center* No	*Freestanding facility, Ambulatory surgical center or in a Physician's office* Yes *Outpatient Hospital-based surgical center* Yes	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound.			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Transplantation Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	For Network Benefits, transplantation services must be received from a Designated Provider. The Claims Administrator does not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Urgent Care Center Services			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$100 per visit	50%	In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	No	Yes	
Urinary Catheters			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	50%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	
Virtual Care Services			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Out-of-Network Benefits are not available.	Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Out-of-Network Benefits are not available.	
Does the Annual Deductible Apply?	No	Out-of-Network Benefits are not available.	

Balanced Plan with UHPD and POST			
Covered Health Care Service	**The Amount You Pay Designated Network and Network**	**The Amount You Pay Out-of-Network**	**What are the Limitations & Exceptions?**
Wigs			
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	30%	30%	Limited to $500 per lifetime.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	Yes	
Does the Annual Deductible Apply?	Yes	Yes	

Allowed Amounts

Allowed Amounts are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Out-of-Network Benefits, except as described below, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Allowed Amounts.
    - For Covered Health Care Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
    - For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
    - For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
    - For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

Allowed Amounts are determined in accordance with the Claims Administrator's reimbursement policy guidelines, or as required by law, as described in the SPD.

Designated Network Benefits and Network Benefits

Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Designated Network and Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by the Claims Administrator, Allowed Amounts are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Out-of-Network Benefits

When Covered Health Care Services are received from an out-of-Network provider as described below, Allowed Amounts are determined as follows:

- **For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary, the Allowed Amount is based on one of the following in the order listed below as applicable:
    - The reimbursement rate as determined by a state *All Payer Model Agreement*.
    - The reimbursement rate as determined by state law.
    - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Claims Administrator.
    - The amount determined by *Independent Dispute Resolution (IDR)*.

  For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

  IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Emergency Health Care Services provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
    - The reimbursement rate as determined by a state *All Payer Model Agreement*.
    - The reimbursement rate as determined by state law.
    - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Claims Administrator.
    - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Air Ambulance transportation provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
    - The reimbursement rate as determined by a state *All Payer Model Agreement*.
    - The reimbursement rate as determined by state law.
    - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Claims Administrator.
    - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the rates that

would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

When Covered Health Care Services are received from an out-of-Network provider, except as described above, Allowed Amounts are determined as follows: an amount negotiated by the Claims Administrator, a specific amount required by law (when required by law), or an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the out-of-Network provider, the applicable Coinsurance, Copayment or any deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Allowed Amount (which includes your Coinsurance, Copayment, and deductible) is yours.

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to out-of-network providers that have questions about the Allowed Amounts and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Allowed Amount, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Participants (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Allowed Amount for that particular claim.

Provider Network

The Claims Administrator or its affiliates arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not ClubCorp USA, Inc. or the Claims Administrator's employees. It is your responsibility to choose your provider.

The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card to request a copy. If you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits. However, if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with the Claims Administrator to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Some Network providers choose to be a Network provider for only some of the Claims Administrator's products. Refer to your provider directory or contact the Claims Administrator for help.

Designated Providers

If you have a medical condition that the Claims Administrator believes needs special services, the Claims Administrator may direct you to a Designated Provider chosen by the Claims Administrator. If you require certain complex Covered Health Care Services for which expertise is limited, the Claims Administrator may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Care Services from a Designated Provider, the Plan may reimburse certain travel expenses.

In both cases, Network Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by the Claims Administrator.

You or your Network Physician must notify the Claims Administrator of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify the Claims Administrator in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Network Benefits will not be paid. Out-of-Network Benefits may be available if the special needs services you receive are Covered Health Care Services for which Benefits are provided under the Plan.

Health Care Services from Out-of-Network Providers Paid as Network Benefits

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify the Claims Administrator and, if the Claims Administrator confirms that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through an out-of-Network provider.

Limitations on Selection of Providers

If the Claims Administrator determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, the Claims Administrator may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date the Claims Administrator notifies you, the Claims Administrator will select a single Network Physician for you.

If you do not use the selected Network Physician, Covered Health Care Services will be paid as Out-of-Network Benefits.

Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Plan is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Plan.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Plan.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the *Schedule of Benefits*.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount or the Recognized Amount when applicable, you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying the Claims Administrator.

Please note that in listing services or examples, when the Plan says "this includes," it is not the Claims Administrator's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Plan states specifically that the list "is limited to."

Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as the Claims Administrator determines appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.

- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

  - "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
  - "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
  - "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services.*

Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
  - The provision of the Experimental or Investigational Service(s) or item.
  - The clinically appropriate monitoring of the effects of the service or item, or

  - The prevention of complications.

- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. The Claims Administrator may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Plan.

Congenital Heart Disease (CHD) Surgeries

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.
- Tetralogy of fallot.
- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for CHD services.

Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).

- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon your medical needs include:

- Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.
- Blood glucose meters including continuous glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.

Durable Medical Equipment (DME), Orthotics and Supplies

Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.
- Cranial molding helmets (cranial banding).

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998.*

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.]

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

Benefits do not include:

- Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *SPD*.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
- Powered exoskeleton devices.

The Claims Administrator will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Medical Supplies and Equipment.*

Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits are not available for services to treat a condition that does not meet the definition of an Emergency.

Enteral Nutrition

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
- Severe food allergies.
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

For the purpose of this Benefit, "enteral formulas" include:

- Amino acid-based elemental formulas.
- Extensively hydrolyzed protein formulas.
- Modified nutrient content formulas.

For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment.
- Chronic physical disability.
- Intellectual disability; or
- Loss of life.

Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a disabling condition to learn or improve skills and functioning for daily living. The Claims Administrator will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy including Cognitive therapy.
- Manipulative Treatment.

- Speech therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:

- Treatment is administered by any of the following:
  - Licensed speech-language pathologist.
  - Licensed audiologist.
  - Licensed occupational therapist.
  - Licensed physical therapist.
  - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Vocational training.
- Residential Treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

The Claims Administrator may require the following be provided:

- Treatment plan.
- Medical records.
- Clinical notes.
- Other necessary data to allow the Claims Administrator to prove that medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress that is capable of being demonstrated, the Claims Administrator may request a treatment plan that includes:

- Diagnosis.
- Proposed treatment by type, frequency, and expected duration of treatment.
- Expected treatment goals.
- Frequency of treatment plan updates.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices*.

Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's guidelines for hospice care.

Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Infertility Services

Services for the treatment of infertility when provided by or under the care or supervision of a Physician, limited to the following procedures:

- Ovulation induction (or controlled ovarian stimulation).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).

- Assisted Reproductive Technologies (ART).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

To be eligible for Benefits, you must meet all of the following:

- You are not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:
  - One year, if you are a female under age 35.
  - Six months, if you are a female age 35 or older.
- You are a female under age 44.
- You have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

For the purposes of this Benefit, "therapeutic donor insemination" means insemination with a donor sperm sample for the purpose of conceiving a child.

Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- Lab and radiology/X-ray.
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Mental Health Care and Substance-Related and Addictive Disorders Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Mental Health Care Services for Autism Spectrum Disorder (otherwise known as neurobiological disorders) that are both of the following:
    - Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
    - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

  This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this *SPD*.

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. (“AbleTo Therapy360 Program”) for Covered Persons with certain co-occurring behavioral and medical conditions.

AbleTo Therapy360 Program provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

Obesity - Weight Loss Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:

- You have a body mass index (BMI) of greater than 40.
- You have a body mass index (BMI) of greater than 35 with complicating coexisting medical conditions or diseases (such as sleep apnea or diabetes) directly related to, or made worse by, obesity.

Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pharmaceutical Products - Outpatient

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by the Claims Administrator), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *SPD*.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, the Claims Administrator may direct you to a Designated Dispensing Entity. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

The Claims Administrator may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or

participation in health management programs. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Benefits include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

The Claims Administrator also has special prenatal programs to help during Pregnancy. They are voluntary and there is no extra cost for taking part in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the expected date of delivery. It is important that you notify the Claims Administrator regarding your Pregnancy.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

  If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

  - Which pump is the most cost effective.
  - Whether the pump should be purchased or rented (and the duration of any rental).
  - Timing of purchase or rental.

Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *SPD*.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Devices, Appliances and Prosthetics*.

Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy including Cognitive rehabilitation therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder

results from Injury, cerebral vascular accident, cancer or Congenital Anomaly. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include:

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

Transplantation Services

Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies.

- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Plan, limited to donor:

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for transplant services.

Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Urinary Catheters

Benefits for indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

Virtual Care Services

Virtual care for Covered Health Care Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at myuhc.com or the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video-conferencing or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, or fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

Wigs

Wigs and other scalp hair prosthesis covered for medically induced hair loss due to chemo or radiation treatments.

Section 2: Exclusions and Limitations

How Are Headings Used in this Section?

To help you find exclusions, this section contains headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

Plan Does Not Pay Benefits for Exclusions

The Plan will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through an SMM or Amendment to the Plan.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services*, those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when the exclusion or limitation says that "this includes," it is not the Plan's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the exclusion or limitation will state specifically that the list "is limited to."

Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.
7. Art therapy, music therapy, dance therapy, animal-assisted therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

   This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

   - Transplant preparation.
   - Prior to the initiation of immunosuppressive drugs.
   - The direct treatment of acute traumatic Injury, cancer or cleft palate.

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Removal, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.

2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.

3. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.

- Non-wearable external defibrillator.
- Trusses.
- Ultrasonic nebulizers.

4. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. External cochlear devices and systems.
8. Powered and non-powered exoskeleton devices

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by the Claims Administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator’s designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services*.
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of

safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year.
11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*

Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
    - Cleaning and soaking the feet.
    - Applying skin creams in order to maintain skin tone.
    - This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

Gender Dysphoria

1. Cosmetic Procedures, including the following:
    - Abdominoplasty.

- Blepharoplasty.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.

   This exclusion does not apply to:

   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices* in *Section 1: Covered Health Care Services*. This exception does not apply to supplies for the administration of medical food products.
   - Diabetic supplies for which Benefits are provided as described under Diabetes Services in *Section 1: Covered Health Care Services*.

- Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Care Services*.
- Urinary catheters and related urologic supplies for which Benefits are provided as described under Urinary Catheters in *Section 1: Covered Health Care Services*.

2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Mental Health Care and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.
8. Non-Medical 24-Hour Withdrawal Management.
9. High intensity residential care, including *American Society of Addiction Medicine (ASAM) Criteria* for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.
10. Intensive Behavioral Therapies such as Applied Behavior Analysis for Autism Spectrum Disorders.

Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional

education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services.*
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot and cold compresses.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.
   - Motorized beds.
   - Music devices.
   - Personal computers.
   - Pillows.

- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).

3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.

5. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer or Congenital Anomaly.

6. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

7. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident or stroke.

8. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.

9. Biofeedback.

10. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.

12. Non-surgical treatment of obesity.

13. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

14. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

15. Helicobacter pylori (H. pylori) serologic testing.

16. Intracellular micronutrient testing.

Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal address.

3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

- Has not been involved in your medical care prior to ordering the service, or
- Is not involved in your medical care after the service is received.

This exclusion does not apply to mammography.

Reproduction

1. The following Infertility treatment-related services:

   Cryo-preservation and other forms of preservation of reproductive materials except as described under *Infertility Services*.
   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
   - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
   - Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
   - Ovulation predictor kits.

2. The following services related to Gestational Carrier or Surrogate:
   - Fees for the use of a Gestational Carrier or Surrogate.
   - Insemination costs of Surrogate or transfer embryo to Gestational Carrier.
   - IVF for a traditional Surrogate.
   - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
   - Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval. This exclusion may not apply to certain procedures related to Assisted Reproductive Technologies (ART) as described under *Infertility Services* including the cost for fertilization (in vitro fertilization or intracytoplasmic sperm injection), embryo culture, and embryo transfer.
   - Donor sperm – The cost of procurement and storage of donor sperm. This exclusion may not apply to certain insemination procedures as described under *Infertility Services* including thawing and insemination.

4. The reversal of voluntary sterilization.

5. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility.

6. Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

7. Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).

8. Infertility treatment following unsuccessful reversal of voluntary sterilization.

9. Infertility Treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

Services Provided under another Plan

1. Health care services for which other coverage is required by federal, state or local law to be bought or provided through other arrangements. This includes coverage required by workers' compensation, or similar legislation. This exclusion does not apply to Plan Sponsor's that are not required by law to buy or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)
3. Health care services for transplants involving animal organs.

Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back at the Claims Administrator's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services.*

Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.
6. Rest cures.
7. Services of personal care aides.
8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses with the exception of one set of lenses (contacts of frame-type) following the surgery. Coverage for lenses is provided at the Network level for Network or Non-Network Benefits.
2. Routine vision exams, including refractive exams to determine the need for vision correction.
3. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Cost and related fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.

All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this *SPD* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Plan when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under the Plan ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Plan ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event an out-of-Network provider waives, does not pursue, or fails to collect Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived.

7. Charges in excess of the Allowed Amount or in excess of any specified limitation.

8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.

9. Autopsy.

10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.

11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services the Claims Administrator would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Plan Sponsor. The Plan Sponsor will submit the completed forms to the Claims Administrator, along with any required contribution. The Plan will not provide Benefits for health care services that you receive before your effective date of coverage.

To enroll, call the Plan Sponsor within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. If you wish to change your benefit elections due to your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the Plan Sponsor within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

Eligible persons may enroll in coverage using the enrollment form provided by the Plan Sponsor or the electronic means of enrollment provided by the plan sponsor provided such enrollments are completed by the deadline established by the plan sponsor. The individual has the obligation to determine which benefit option under the *Schedule of Benefits* is best for the individual and his or her dependents. An eligible Employee may enroll him or herself and his or her Dependents in the benefit option he or she selects for himself or herself and all eligible dependent children or Spouse. An eligible Employee may not enroll any Dependents in a benefit option in which the eligible Employee is not enrolled for the calendar year.

Cost of Coverage

You and the Plan Sponsor share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld. In most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and the Plan Sponsor reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Plan Sponsor.

What If You Are Hospitalized When Your Coverage Begins?

The Plan will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Plan.

These Benefits are subject to your previous carrier's obligations under state law or contract.

You should notify the Claims Administrator of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible. For plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Care Services from Network providers.

Who Is Eligible for Coverage?

The Plan Sponsor determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee of the Plan Sponsor who (or other person whose connection with the Plan Sponsor) meets the eligibility rules. When an Eligible Person enrolls, the Claims Administrator refers to that person as an Employee. For a complete definition of Eligible Person, Plan Sponsor and Employee, see *Section 9: Defined Terms*.

You are eligible to enroll in the Plan if you are a regular full-time Employee who is scheduled to work at least 30 hours per week.

Eligible Persons must live within the United States.

If both spouses are Eligible Persons of the Plan Sponsor, each may enroll as an Employee or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Employee's spouse and children. When a Dependent enrolls, the Claims Administrator refers to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your Spouse.
- Your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- An unmarried child age 26 or over who is or becomes disabled and dependent upon you.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Plan Sponsor purchases coverage under the Plan from the Claims Administrator, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Plan. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

The Plan Sponsor sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Plan Sponsor. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Plan Sponsor. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Employee's may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.

Coverage for the Dependent begins on the date of the event. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the event.

Domestic Partner Coverage

Same & opposite sex domestic partners must either be married or fall under Common Law Marriages for the following states:

- Alabama
- Colorado
- District of Columbia
- Georgia (if created before 1/1/97)
- Idaho (if created before 1/1/96)

- Iowa
- Kansas
- Montana
- New Hampshire (for inheritance purposes only)
- Ohio (if created before 10/10/91)
- Oklahoma (possibly only if created before 11/1/98. Oklahoma's laws and court decisions may be in conflict about whether common law marriages formed in that state after 11/1/98 will be recognized.)
- Pennsylvania (if created before 1/1/05)
- Rhode Island
- South Carolina
- Texas
- Utah

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including legal separation, divorce or death).

- The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
- In the case of COBRA continuation coverage, the coverage ended.
- The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
- The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. The Plan Sponsor must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

Reinstatement of Coverage

An Employee who is terminated and rehired will be treated as a New Employee upon rehire only if the Employee was not credited with an Hour of Service with the Employer (or any member of the controlled or affiliated group) for a period of at least 13 consecutive weeks immediately preceding the date of rehire.

A Variable Hour Employee who is terminated and rehired will be treated as a continuing Employee upon rehire only if the Employee break in service did not exceed 13 weeks. Upon return, coverage will be effective immediately, so long as all other eligibility criteria are satisfied.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, the Plan Sponsor may end the Plan and/or all similar benefit plans at any time for the reasons explained in the Plan.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Claims Administrator will still process Plan payments on claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, the Claims Administrator will not process Plan payments on claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Employee's coverage ends.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Plan Ends**

  Your coverage ends on the date the Plan ends. In this event, the Plan Sponsor is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be an Employee or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Employee," "Dependent" and "Enrolled Dependent."

- **The Claims Administrator Receives Notice to End Coverage**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends on the date the Claims Administrator receives the required notice from the Plan Sponsor to end your coverage, or on the date requested in the notice, if later.

- **Employees Retires ~~or Is Pensioned~~**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends the date the Employee is retired or receiving benefits under the Plan Sponsor 's pension or retirement plan.

  This provision applies unless there is specific coverage classification for retired ~~or pensioned~~ persons in the Plan, and only if the Employee continues to meet any applicable eligibility requirements. The Plan Sponsor can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

The Plan will provide at least 30 days advance required notice to the Employee that coverage will end on the date identified in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing

incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If the Claims Administrator and the Plan Sponsor find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact the Plan Sponsor has the right to demand that you pay back all Benefits the Plan paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. The Plan will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental or physical handicap or disability.
- The Enrolled Dependent child depends mainly on the Employee for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Plan.

You must furnish the Plan Sponsor with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before the Plan Sponsor agrees to this extension of coverage for the child, the Plan Sponsor may require that a Physician examine the child. The Plan Sponsor will choose the Physician and the Plan will pay for that examination.

The Plan Sponsor may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at the Plan's expense. The Plan Sponsor will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of the Plan Sponsor's request as described above, coverage for that child will end.

Continuation of Coverage

If your coverage ends under the Plan, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Plan Sponsors that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Plan Sponsor is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Plan, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

The Claims Administrator is not the Plan Sponsor's designated "plan administrator" as that term is used in federal law, and the Claims Administrator does not assume any responsibilities of a "plan administrator" according to federal law.

The Claims Administrator is not obligated to provide continuation coverage to you if the Plan Sponsor or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Plan Sponsor or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying the Claims Administrator in a timely manner of your election of continuation coverage.

Section 5: How to File a Claim

Claims Procedures

You can obtain a claim form by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. If you do not have a claim form, attach the bill from your provider to a brief letter of explanation. Verify that your provider's bill contains the *Required Information* listed below. If any *Required Information* is missing from the bill, you can include it in your letter.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Claims Administrator. You must file the claim in a format that contains all of the information the Claims Administrator requires, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to the Claims Administrator within one year of the date of service, Benefits for that health care service will be denied or reduced, as determined by the Claims Administrator. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from the Claims Administrator, you must provide the Claims Administrator with all of the following information:

- The Employee's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with the Claims Administrator at the address on your ID card.

Payment of Benefits

Except as required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*, you may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall

be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to “third parties” include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan’s obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans’ overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments in Section 7: Coordination of Benefits*.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in a form of other consideration that the Claims Administrator in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes to other plans for which the Claims Administrator processes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to the Claims Administrator in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. The Claims Administrator will notify you of the decision regarding your complaint within 60 days of receiving it.

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact the Claims Administrator in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

For medical claims, the appeals address is:

UnitedHealthcare - Appeals

P.O. Box 30432,

Salt Lake City, Utah 84130-0432

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. The Claims Administrator may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by the Claims Administrator during the determination of the appeal, the Claims Administrator will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the decision letter to you.

Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. The Claims Administrator will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If the Claims Administrator needs more information from your Physician to make a decision, the Claims Administrator will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

External Review Program

You may be entitled to request an external review of the Claims Administrator's determination after exhausting your internal appeals if either of the following apply:

- You are not satisfied with the determination made by the Claims Administrator.
- The Claims Administrator fails to respond to your appeal within the timeframe required by the applicable regulations.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting the Claims Administrator at the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received the Claims Administrator's final appeal decision.

An external review request should include all of the following:

- A specific request for an external review.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization (IRO)*. The Claims Administrator has entered into agreements with three or more *IRO*s that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review includes all of the following:

- A preliminary review by the Claims Administrator of the request.
- A referral of the request by the Claims Administrator to the *IRO*.
- A decision by the *IRO*.

After receipt of the request, the Claims Administrator will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes this review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign an *IRO* to conduct such review. The Claims Administrator will assign requests by either rotating the assignment of claims among the *IRO*s or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days following the date you receive the *IRO*'s request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned *IRO* the documents and information considered in making UnitedHealthcare's determination. The documents include:

The Claims Administrator will provide to the assigned *IRO* the documents and information considered in making the Claims Administrator's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by the Claims Administrator.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request. The Claims Administrator will include it with the documents forwarded to the *IRO.*

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by the Claims Administrator. The *IRO* will provide written notice of its determination (the *"Final External Review Decision"*) within 45 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External*

Review Decision to you and the Claims Administrator, and it will include the clinical basis for the determination.

If the Claims Administrator receives a *Final External Review Decision* reversing the Claims Administrator's determination, the Plan will provide coverage or payment for the Benefit claim at issue according to the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the *Final External Review Decision* agrees with the Claims Administrator's determination, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter for the expedited external review, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review, separately or at the same time you have filed a request for an expedited internal appeal, if you receive either of the following:

- An adverse benefit determination of a claim or appeal that involves a medical condition for which the time frame for completion of an expedited internal appeal would either jeopardize:
    - The life or health of the individual.
    - The individual's ability to regain maximum function.

In addition, you must have filed a request for an expedited internal appeal.

- A final appeal decision, that either:
    - Involves a medical condition where the timeframe for completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.
    - Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.

Immediately upon receipt of the request, the Claims Administrator will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the review, the Claims Administrator will send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator will assign an *IRO* in the same manner the Claims Administrator utilizes to assign standard external reviews to *IRO*s. The Claims Administrator will provide all required documents and information the Claims Administrator used in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available method in a timely manner. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by the Claims Administrator. The *IRO* will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances

require, but in no event more than 72 hours after the *IRO* receives the request. If the IRO's final external review decision is first communicated verbally, the *IRO* will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

You may call the Claims Administrator at the telephone number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Urgent Care Request for Benefits*

Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits to the Claims Administrator within:	48 hours after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	72 hours
If the Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an urgent care request for Benefits.

Pre-Service Request for Benefits*

Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	15 days
You must then provide completed request for Benefits information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial request for Benefits is complete, within:	15 days
• after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*The Claims Administrator may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial claim is complete, within:	30 days
• after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the Primary Plan. How much this Plan will reimburse you, if anything, will also depend in part on the Allowable Expense. The term, “Allowable Expense,” is further explained below.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan.** The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) 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 subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are 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.

(d) The Plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off 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. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. 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. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Care Services by following the steps below.

- The Plan determines the amount it would have paid based on the Allowable Expense.
- If this Plan would have paid the same amount or less than the Primary Plan paid, this Plan pays no Benefits.

- If this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference.

You will be responsible for any applicable Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the Allowable Expense.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is an Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that meets the definition of a Covered Health Care Services under this Plan.

When the provider is a Network provider for both the Primary Plan and this Plan, the Allowable Expense is the Primary Plan's network rate. When the provider is a network provider for the Primary Plan and a non-Network provider for this Plan, the Allowable Expense is the Primary Plan's network rate. When the provider is a non-Network provider for the Primary Plan and a Network provider for this Plan, the Allowable Expense is the reasonable and customary charges allowed by the Primary Plan. When the provider is a non-Network provider for both the Primary Plan and this Plan, the Allowable Expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "*Determining the Allowable Expense When this Plan is Secondary to Medicare*".

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, domestic partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the Allowable Expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from an Opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits,

Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will treat the provider's billed charges for covered services as the Allowable Expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on your ID card.

Right to Receive and Release Needed Information?

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future Allowed Amounts.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Section 8: General Legal Provisions

What Is Your Relationship with the Claims Administrator and Plan Sponsor?

It is important for you to understand the Claims Administrator's role with respect to the Plan and how it may affect you. The Claims Administrator helps administer the claims payment for the Plan Sponsor's Plan in which you are enrolled. The Claims Administrator and the Plan Sponsor do not provide medical services or make treatment decisions. This means:

- The Claims Administrator communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Care Services, which are more fully described in this *SPD*.
- The Plan may not pay for all treatments you or your Physician may believe are needed. If the Plan does not pay, you will be responsible for the cost.

The Plan Sponsor and the Claims Administrator may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Plan Sponsor and the Claims Administrator will use individually identifiable information about you as permitted or required by law, including in the Claims Administrator's operations and in the Claims Administrator's research. The Plan Sponsor and the Claims Administrator will use de-identified data for commercial purposes including research.

Please refer to the Claims Administrator's *Notice of Privacy Practices* for details.

What Is the Claims Administrator's Relationship with Providers and Plan Sponsors?

The relationships between the Claims Administrator and Network providers and Plan Sponsors are solely contractual relationships between independent contractors. Network providers and Plan Sponsors are not the Claims Administrator's agents or employees. Neither the Claims Administrator nor any of the Claims Administrator's employees are agents or employees of Network providers or the Plan Sponsor's.

Plan Sponsors and the Claims Administrator do not provide health care services or supplies, or practice medicine. Plan Sponsors and the Claims Administrator arrange for health care providers to participate in a Network and the Claims Administrator processes the Plan's payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. Network providers are not the Plan Sponsor's employees. Network providers are not the Claims Administrator's employees. The Plan Sponsor and the Claims Administrator do not have any other relationship with Network providers such as principal-agent or joint venture. The Plan Sponsor and the Claims Administrator are not responsible for any act or omission of any provider.

The Claims Administrator is not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator is not responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

The Plan Sponsor is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Plan's Service Fee to the Claims Administrator.

- The funding of Benefits on a timely basis.
- Notifying you of when the Plan ends.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Plan Sponsors?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a participant responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds the Allowed Amount.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Plan Sponsor is that of employer and employee, Dependent or other classification as defined in the Plan.

Notice

When the Claims Administrator provides written notice regarding administration of the Plan to an authorized representative of the Plan Sponsor, that notice is deemed notice to all affected Employees and their Enrolled Dependents. The Plan Sponsor is responsible for giving notice to you.

Statements by the Plan Sponsor or Employees

All statements made by the Plan Sponsor or by an Employee shall, in the absence of fraud, be deemed representations and not warranties. The Claims Administrator will not use any statement made by the Plan Sponsor to void the Plan after it has been in force for two years unless it is a fraudulent statement.

Does the Claims Administrator Pay Incentives to Providers?

The Claims Administrator pays Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.

- Capitation - a group of Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The applicable Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Copayment and/or Coinsurance as described in your *Schedule of Benefits*.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

Are Incentives Available to You?

Sometimes the Claims Administrator may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, you should discuss taking part in such programs with your Physician. Contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card if you have any questions.

Does the Claims Administrator Receive Rebates and Other Payments?

The Plan Sponsor and the Claims Administrator may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. The Plan Sponsor and the Claims Administrator may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copayments or Coinsurance.

Who Interprets Benefits and Other Provisions under the Plan?

The Plan Sponsor and the Claims Administrator have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions set out in the Plan, including this *SPD*, the *Schedule of Benefits* and any *Summary Material Modifications (SMM)*, and/or Amendments.

- Make factual determinations related to the Plan and its Benefits.

The Plan Sponsor and the Claims Administrator may assign this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan Sponsor may offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that the Plan Sponsor does so in any particular case shall not in any way be deemed to require the Plan Sponsor to do so in other similar cases.

Who Provides Administrative Services?

The Claims Administrator provides claims administrative services or, as the Claims Administrator determines, the Claims Administrator may arrange for various persons or entities to provide claims administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as the Claims Administrator determines. The Claims Administrator is not required to give you prior notice of any such change, nor is the Claims Administrator required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

What is the Future of the Plan?

Although Plan Sponsor expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or *Employee Retirement Income Security Act of 1974 (ERISA)*, or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Amendments to the Plan

To the extent permitted by law, the Plan Sponsor has the right, as it determines and without your approval, to change, interpret, withdraw or add Benefits or end the Plan.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of applicable state law provisions not otherwise preempted by ERISA or federal statutes or regulations (of the jurisdiction in which the Plan is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Plan unless it is made by an Amendment or SMM. All of the following conditions apply:

- Amendments to the Plan are effective upon the Plan's next anniversary date, except as otherwise permitted by law.

- SMMs to the Plan are effective on the date the Plan Sponsor specifies.
- No agent has the authority to change the Plan or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Plan.

How Does the Claims Administrator Use Information and Records?

The Claims Administrator may use your individually identifiable health information as follows:

- To administer the Plan and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

The Claims Administrator may request additional information from you to decide your claim for Benefits. The Claims Administrator will keep this information confidential. The Claims Administrator may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how the Claims Administrator may use or disclose your information is found in the Claims Administrator *Notice of Privacy Practices.*

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Claims Administrator with all information or copies of records relating to the services provided to you. The Claims Administrator has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Employee's enrollment form. UnitedHealthcare agrees that such information and records will be considered confidential.

The Claims Administrator has the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Plan.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Plan, the Claims Administrator and the Claims Administrator's related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to the Claims Administrator *Notice of Privacy Practices.*

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from the Claims Administrator, the Claims Administrator also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as needed. The Claims Administrator's designees have the same rights to this information as the Claims Administrator has.

Does the Plan Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, the Plan Sponsor may require that a Network Physician of its choice examine you at the Plan's expense.

Is Workers' Compensation Affected?

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

The Plan has the right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation Example:

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement Example:

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- Your employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or the Plan's agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or the Plan's agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.

- By participating in and accepting Benefits under the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile Plan - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without the Plan's written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of the Plan's interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the

extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of the Plans discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

When Does the Plan Receive Refunds of Overpayments?

If the Plan pays Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to the Plan if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

Is There a Limitation of Action?

You cannot bring any legal action against the Plan or the Claims Administrator to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against the Plan or the Claims Administrator you must do so within three years of the date the Plan notified you of its final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator.

What Is the Entire Plan?

The *SPD*, the *Schedule of Benefits*, and any SMMs and/or Amendments, make up the entire Plan.

Section 9: Defined Terms

Addendum - any attached written description of additional or revised provisions to the Plan. The Benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Air Ambulance – medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance as defined in *42 CFR 414.605*.

Allowed Amounts - for Covered Health Care Services, incurred while the Plan is in effect, Allowed Amounts are determined by the Claims Administrator or as required by law as shown in the *Schedule of Benefits*.

Allowed Amounts are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops these guidelines, in its discretion, after review of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Alternate Facility - a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Plan. It is effective only when distributed by the Plan Sponsor or Plan Administrator. It is subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Ancillary Services - items and services provided by out-of-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by an out-of-Network Physician when no other Network Physician is available.

Annual Deductible - the total of the Allowed Amount, or the Recognized Amount when applicable, you must pay for Covered Health Care Services per year before the Plan will begin paying for Benefits. It

does not include any amount that exceeds Allowed Amounts or the Recognized Amount when applicable. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Care Services that are available under the Plan.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Claims Administrator - the organization that provides certain claim administration and other services for the Plan.

Coinsurance - the charge, stated as a percentage of the Allowed Amount or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Care Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Copayment.
- The Allowed Amount, or the Recognized Amount when applicable.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

- Medically Necessary.
- Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in this *SPD* under *Section 2: Exclusions and Limitations*.
- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness and Substance-Related and Addictive Disorders, or their symptoms.
- Consistent with nationally recognized scientific evidence as available and prevailing medical standards and clinical guidelines. In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:
    - "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
    - "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.

- Provided to a Covered Person who meets the Plan's eligibility requirements.
- Not excluded in this *SPD* under *Section 2: Exclusions and Limitations.*

Covered Person - the Employee or a Dependent, but this term applies only while the person is enrolled under the Plan. The Plan Sponsor uses "you" and "your" in this *SPD* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - the Employee's legal spouse or a child of the Employee or the Employee's spouse. As described in *Section 3: When Coverage Begins*, the Plan Sponsor determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Employee or the Employee's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Plan Sponsor is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A Dependent includes an unmarried child age 26 or older who is or becomes disabled and dependent upon the Employee.

The Employee must reimburse the Plan for any Benefits paid during a time a child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies or Network providers are Designated Dispensing Entities.

Designated Network Benefits - the description of how Benefits are paid for certain Covered Health Care Services provided by a provider or facility that has been identified as a Designated Provider. The Schedule of Benefits will tell you if your plan offers Designated Network Benefits and how they apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Care Service for the treatment of specific diseases or condition; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Care Services through live audio and video technology.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an employee of the Plan Sponsor or other person connected to the Plan Sponsor who meets the eligibility requirements shown in both the Plan Sponsor's Plan and supporting documents. An Eligible Person must live within the United States.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Health Care Services - with respect to an Emergency:

- An appropriate medical screening exam (as required under section *1867 of the Social Security Act, 42 U.S.C.* 1395dd or as would be required under such section if such section applied to an *Independent Freestanding Emergency Department*) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which

such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.

- Emergency Health Care Services include items and services otherwise covered under the Plan when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:

  a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

  b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

  c) The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

  d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

  e) Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Enrolled Dependent - a Dependent who is properly enrolled under the Plan.

Employee - a full-time Employee of the Plan Sponsor who meets the eligibility requirements specified in the Plan. An Employee must live and/or work in the United States.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
- The Claims Administrator may, as the Claims Administrator determines, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
  - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services*: and

- You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - A Gestational Carrier is a female who becomes pregnant fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Independent Freestanding Emergency Department - a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Care Services.

Infertility - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Plan.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Treatment - a structured outpatient treatment program.

- For Mental Health Care Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health.

Intermittent Care - skilled nursing care that is provided either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medicaid - a federal program administered and operated individually by participating state and territorial governments. The program provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary - health care services that are all of the following as determined by the Claims Administrator or the Claims Administrator's designee.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.

- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator has the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by the Claims Administrator.

The Claims Administrator develops and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting the Claims Administrator's determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCProvider.com.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Care Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by the Claims Administrator, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with the Claims Administrator's affiliate to participate in the Claims Administrator's Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of the Claims Administrator's

products. In this case, the provider will be a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates:

- The date it is placed on a tier by the Claims Administrator's PDL Management Committee.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria* providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Plan. The Plan Sponsor sets the period of time that is the Open Enrollment Period.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications, products or devices administered in connection with a Covered Health Care Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that the Claims Administrator describes a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - the Plan Sponsor's Self-Funded group health benefit plan.

The "What Is the *Summary Plan Description*?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

Plan Sponsor - the employer, or other defined or otherwise legally established group, to whom the Plan is issued. The "What Is the *Summary Plan Description*?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

Pregnancy - includes all of the following:

- Prenatal care.

- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Recognized Amount - the amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Care Services when provided by out-of-Network providers:

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

1) An *All Payer Model Agreement* if adopted,

2) State law, or

3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by an out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, approved by the Mental Health/Substance-Related and Addictive Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance-Related and Addictive Disorder Designee.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Secretary - as that term is applied in the *No Surprises Act* of the C*onsolidated Appropriations Act (P.L. 116-260)*.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Service Fee - the periodic fee required for each Employee and each Enrolled Dependent, in accordance with the terms of the Plan.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *SPD* includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse - an individual to whom you are legally married.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Summary Material Modification (SMM) - any attached written description of additional Covered Health Care Services not described in this *SPD.* Covered Health Care Services provided by a SMM may be subject to payment of additional Service Fees. SMMs are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the SMM.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Therapeutic Donor Insemination (TDI): Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living - Mental health care services and substance-related and addictive disorders services provided through facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria* and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

The Claims Administrator has a process by which the Claims Administrator compiles and reviews clinical evidence with respect to certain health care services. From time to time, the Claims Administrator issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) the Claims Administrator may, as the Claims Administrator determines, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

Clinical Programs and Resources

Care Management

Care Management Solutions

Personal Health Support

The Claims Administrator provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, the Claims Administrator may assign to you a primary nurse, referred to as a Personal Health Support Nurse, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CKD stage 4/5 or ESRD throughout your care path.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Complex Medical Conditions, Programs and Services

Cancer Resource Services (CRS) Program

Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about CRS, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Travel and Lodging Assistance Program*.

Cancer Support Program

The Claims Administrator provides a program that identifies and supports a Covered Person who has cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer support and education on cancer, and self-care strategies treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on your ID card or call the program directly at 1-866-936-6002.

Congenital Heart Disease (CHD) Resource Services

The Claims Administrator provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call the Claims Administrator at the number on your ID card.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Care Service under the Plan.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Travel and Lodging Assistance Program*.

Kidney Disease Programs

Comprehensive Kidney Solution (CKS) program

For Participants diagnosed with Kidney Disease, your Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) through End-stage Renal Disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a "best practices" approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card.

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, please contact CKS of your decision.

Kidney Resource Services (KRS) program End-Stage Renal Disease (ESRD)

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Transplant Resource Services (TRS) Program

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Travel and Lodging Assistance Program*.

Travel and Lodging Assistance Program

Your Plan Sponsor is providing you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Allowed Amounts are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Allowed Amount for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.

- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Facility.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Decision Support

In order to help you make informed decisions about your health care, the Claims Administrator has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- Access to health care information.
- Support by a nurse to help you make more informed decisions in your treatment and care.
- Expectations of treatment.
- Information on providers and programs.

Conditions for which this program is available include:

- Back pain.
- Knee & hip replacement.
- Prostate disease.
- Prostate cancer.
- Benign uterine conditions.
- Breast cancer.
- Coronary disease.
- Bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Disease Management

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
    - Education about the specific disease and condition.
    - Medication management and compliance.
    - Reinforcement of on-line behavior modification program goals.
    - Preparation and support for upcoming Physician visits.
    - Review of psychosocial services and community resources.
    - Caregiver status and in-home safety.
    - Use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Health Management Virtual Behavioral Health Therapy and Coaching Programs

The Virtual Behavioral Health Therapy and Coaching program identifies Covered Persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for Covered Persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You’re encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for behavioral health. You can visit the site by going to myuhc.com.

The program is provided through AbleTo, Inc. Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Women's Health/Reproductive

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get educational information and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Consumer Solutions and Self-Service Tools

Plan Sponsor believes in giving you tools to help you be an educated health care consumer. To that end, Plan Sponsor has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the health care system.

NOTE: Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make more informed health care decisions and take a greater responsibility for your own health. The Claims Administrator and the Plan Sponsor are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

www.myuhc.com

UnitedHealthcare's member website, www.myuhc.com, provides information at your fingertips anywhere and anytime you have access to the Internet. www.myuhc.com opens the door to a wealth of health information and self-service tools.

With www.myuhc.com you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Access all of the content and wellness topics from NurseLine[SM].
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

If you have not already registered on www.myuhc.com, simply go to www.myuhc.com and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit www.myuhc.com and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?

Log on to www.myuhc.com and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Health Survey

You are invited to learn more about health and wellness at www.myuhc.com and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

If you need any assistance with the online survey, please call the number on your ID card.

Reminder Programs

To help you stay healthy, the Claims Administrator may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- Mammograms for women.

- Pediatric and adolescent immunizations.
- Cervical cancer screenings for women.
- Comprehensive screenings for individuals with diabetes.
- Influenza/pneumonia immunizations for enrollees.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

UnitedHealth Premium® Designation Program

To help people make more informed choices about their health care, the UnitedHealth Premium® designation program recognizes Network Physicians who meet criteria for quality and cost efficiency. UnitedHealthcare uses national standardized measures to evaluate quality. The cost efficiency criteria rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® designation program including how to locate a Premium Care Physician, log onto www.myuhc.com or call the number on your ID card.

Federal Notice

Language Assistance Services

The Claims Administrator provides free language services to help you communicate with us. The Claims Administrator offers interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card TTY 711. The Claims Administrator is available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: **한국어(Korean)**를 사용하시는경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به‌طور رایگان در اختیار شما می باشد.
1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

(Khmer) 1-866-633-2446.

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

Notice of Non-Discrimination

The Claims Administrator[1] does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

United HealthCare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "The Claims Administrator" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Summary Plan Description (SPD)* and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below. These changes will apply to any "non-grandfathered" plan. Contact your Plan Administrator to determine whether or not your plan is a "grandfathered" or a "non-grandfathered plan". Under the *Patient Protection and Affordable Care Act (PPACA)* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans* at that time.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:

  Ambulatory patient services; emergency services, hospitalization; laboratory services; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.

- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:

  - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000.
  - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000.
  - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

  Please note that for plan years beginning on or after January 1, 2014, essential health benefits cannot be subject to annual or lifetime dollar limits.

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law).

  On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

  Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the plan is subject to the statute known as *Michelle's Law*. This law amends *ERISA*, the *Public Health Service Act*, and the *Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or Injury.

- If you do not have a grandfathered plan, in-network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:

  - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
  - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
  - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
  - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

- Retroactive rescission of coverage under the plan is permitted, with 30 days advance written notice, only in the following two circumstances:

  - The individual performs an act, practice or omission that constitutes fraud.
  - The individual makes an intentional misrepresentation of a material fact.

- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:

  - Direct access to OB/GYN care without a referral or authorization requirement.
  - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
  - Prior authorization is not required before you receive services in the emergency department of a hospital.

If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.

Effective for plans that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered individuals participating in a preventive clinical trial and Phase IV trials. This modification is optional for certain grandfathered health plans. Refer to your plan documents to determine if this modification has been made to your plan.

Pre-Existing Conditions:

Any pre-existing condition exclusions (including denial of benefit or coverage) will not apply to covered persons regardless of age.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or *UnitedHealthcare* for more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call the Claims Administrator at the number listed on your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from the Claims Administrator will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call the Claims Administrator at the number listed on your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits*.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, the Claims Fiduciary will review its decision. The Claims Fiduciary will also send you its written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, the Claims Fiduciary will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call the Claims Administrator at the number listed on your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact the Claims Administrator at the number listed on your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you.

If your plan includes coverage for Mental Health or Substance Use, the following applies:

Mental Health/Substance Use Disorder Parity

Effective for grandfathered and non-grandfathered large group Plans that are new or renewing on or after July 1, 2010, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health conditions and substance use disorder conditions that are Covered Health Care Services under the Plan must be treated in the same manner and provided at the same level as Covered Health Care Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance-Related and Addictive Disorders Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Plan are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Care Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Copayments, Coinsurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Plan, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
if the initial claim is complete, within:	30 days
after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
	decision
The Claims Fiduciary must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, the Claims Administrator will send you written notice of the decision from the Claims Administrator within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, the Claims Administrator will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, the Claims Administrator will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	15 days
You must then provide completed request for Benefits information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial request for Benefits is complete, within:	15 days
• after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Claims Fiduciary must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

*The Claims Administrator may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, the Claims Administrator will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits to the Claims Administrator within:	48 hours after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	72 hours
If the Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an urgent care request for Benefits.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Care* department before requesting a formal appeal. If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Care* representative. If you first informally contact our *Customer Care* department and later wish to request a formal appeal in writing, you should again contact *Customer Care* and request an appeal. If you request a formal appeal, a *Customer Care* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Care* department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health

care professional with appropriate expertise in the field, who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information through the submission of your appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by the Claims Administrator during the determination of the appeal, the Claims Administrator will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of the Claims Administrator's decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

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.

Effective January 1, 2018

The Claims Administrator[2] is required by law to protect the privacy of your health information. The Claims Administrator is also required to send you this notice, which explains how the Claims Administrator may use information about you and when the Claims Administrator can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. The Claims Administrator is required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information the Claims Administrator maintains that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. The Claims Administrator will comply with the requirements of applicable privacy laws relating to notifying you in the event of a breach of your health information.

The Claims Administrator has the right to change its privacy practices and the terms of this notice. If the Claims Administrator makes a material change to its privacy practices, the Claims Administrator will provide to you, in the Claims Administrator's next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. The Claims Administrator will provide you with this information either by direct mail or electronically in accordance with applicable law. In all cases, if the Claims Administrator maintains a website for your particular health plan, the Claims Administrator will post the revised notice on your health plan website, such as www.myuhc.com. The Claims Administrator reserves the right to make any revised or changed notice effective for information the Claims Administrator already has and for information that the Claims Administrator receives in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer the Claims Administrator's business and to provide products, services and information of importance to Plan enrollees. The Claims Administrator maintains physical, electronic and procedural security safeguards in the handling and maintenance of Plan enrollee's information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How the Claims Administrator Uses or Discloses Information

The Claims Administrator must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

The Claims Administrator has the right to use and disclose health information for your treatment, to pay for your health care and to operate the Claims Administrator's business. For example, the Claims Administrator may use or disclose your health information:

- **For Payment** of service fees due the Claims Administrator, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, the Claims Administrator may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** The Claims Administrator may use or disclose health information to aid in your treatment or the coordination of your care. For example, the Claims Administrator may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** The Claims Administrator may use or disclose health information as necessary to operate and manage its business activities related to providing and managing your health care coverage. For example, the Claims Administrator might talk to your physician to suggest a disease management or wellness program that could help improve your health or the Claims Administrator may analyze data to determine how the Claims Administrator can improve its services. The Claims Administrator may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, the Claims Administrator may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, the Claims Administrator may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes**. The Claims Administrator may use or disclose your health information for underwriting purposes; however, the Claims Administrator will not use or disclose your genetic information for such purposes.
- **For Reminders.** The Claims Administrator may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

The Claims Administrator may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** The Claims Administrator may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** The Claims Administrator may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family

member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, the Claims Administrator will use its best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when the Claims Administrator may disclose health information to family members and others involved in a deceased individual's care. The Claims Administrator may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless the Claims Administrator is aware that doing so would be inconsistent with a preference previously expressed by the deceased.

- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** The Claims Administrator may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** The Claims Administrator may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. The Claims Administrator may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** The Claims Administrator may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on the Claims Administrator's behalf or provide the Claims Administrator with services if the information is necessary for such functions or services. The Claims Administrator's business associates are required, under contract with the Claims Administrator, and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in the Claims Administrator's contract as permitted by federal law.

- **Additional Restrictions on Use and Disclosure**. Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
    - 1. HIV/AIDS;
    - 2. Mental health;
    - 3. Genetic tests;
    - 4. Alcohol and drug abuse;
    - 5. Sexually transmitted diseases and reproductive health information; and
    - 6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to the Claims Administrator, it is the Claims Administrator's intent to meet the requirements of the more stringent law. Attached to this notice is a "Federal and State Amendments" document.

Except for uses and disclosures described and limited as set forth in this notice, the Claims Administrator will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give the Claims Administrator authorization to release your health information, the Claims Administrator cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if the Claims Administrator has already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. The Claims Administrator may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while the Claims Administrator will try to honor your request and will permit requests consistent with the Claims Administrator's policies, the Claims Administrator is not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). The Claims Administrator will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, the Claims Administrator will accept your verbal request to receive confidential communications, however; the Claims Administrator may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information the Claims Administrator maintains about you such as claims and case or medical management records. If the Claims Administrator maintains your health information electronically, you will have the right to request that the Claims Administrator send a copy of your health information in an electronic format to you. You

can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, the Claims Administrator may deny your request to inspect and copy your health information. If the Claims Administrator denies your request, you may have the right to have the denial reviewed. The Claims Administrator may charge a reasonable fee for any copies.

- **You have the right to ask to amend** certain health information the Claims Administrator maintains about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If the Claims Administrator denies your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by the Claims Administrator during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require the Claims Administrator to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice on your health plan website, such as www.myuhc.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll- free member phone number on your health plan ID card or you may contact the *UnitedHealth Group Customer Call Center* Representative at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to the Claims Administrator at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with the Claims Administrator at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. The Claims Administrator will not take any action against you for filing a complaint.

[2]This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD

- Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Mountain Health Management Corporation; Rocky Mountain HealthCare Options, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2018

The Claims Administrator[3] is committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with the Claims Administrator, the Claims Administrator may collect personal financial information about you from the following sources:

- Information the Claims Administrator receives from you on applications or other forms, such as name, address, age, medical information and *Social Security* number;
- Information about your transactions with the Claims Administrator, the Claims Administrator's affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

The Claims Administrator does not disclose personal financial information about the Plan's enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of the Claims Administrator's general business practices, the Claims Administrator may, as permitted by law,

disclose any of the personal financial information that the Claims Administrator collects about you without your authorization, to the following types of institutions:

- To the Claims Administrator's corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors:
- To nonaffiliated companies for the Claims Administrator's everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for the Claims Administrator, including sending promotional communications on the Claims Administrator's behalf.

Confidentiality and Security

The Claims Administrator maintains physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-866-633-2446 or TTY 711.

[3]For purposes of this Financial Information Privacy Notice, the "Claims Administrator" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women's and Children's Health, LLC; AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Connextions HCI, LLC; LifePrint East, Inc.; Life Print Health, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

UNITEDHEALTH GROUP

HEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2018

The first part of this Notice, which provides the Claims Administrator's privacy practices for Medical Information, describes how the Claims Administrator may use and disclose your health information under federal privacy rules. There are other laws that may limit the Claims Administrator's rights to use and disclose your health information beyond what the Claims Administrator is allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. Show the categories of health information that are subject to these more restrictive laws; and
2. Give you a general summary of when the Claims Administrator can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & **Drug Abuse Information**
The Claims Administrator is allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
The Claims Administrator is not allowed to use genetic information for underwriting purposes.

Summary of State Laws

General Health Information	
The Claims Administrator is allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AR, CA, DE, NE, NY, PR, RI, UT, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NC, NV
The Claims Administrator is not allowed to use health information for certain purposes.	CA, IA
The Claims Administrator will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
The Claims Administrator must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS
Prescriptions	

The Claims Administrator is allowed to disclose prescription-related information only (1) under certain limited circumstances, and /or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
The Claims Administrator is allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
The Claims Administrator is allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
The Claims Administrator is allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
The Claims Administrator is not allowed to disclose genetic information without your written consent.	CA, CO, KS, KY, LA, NY, RI, TN, WY
The Claims Administrator is allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, ME, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
The Claims Administrator is allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NH, NM, NV, NY, NC, OR, PA, PR, RI, TX, VT, WA, WV, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
The Claims Administrator will collect HIV/AIDS-related information only with your written consent.	OR
Mental Health	
The Claims Administrator is allowed to disclose	CA, CT, DC, IA, IL, IN, KY, MA, ME, MI, NC,

mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
The Claims Administrator is allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, AR, CO, IL, LA, MD, NE, NJ, NY, NM, RI, TN, TX, UT, WI

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act* (*COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the *Employee Benefits Security Administration*.

ERISA Statement

If the Plan Sponsor is subject to *ERISA*, the following information applies to you.

Summary Plan Description

Name of Plan: ClubCorp USA, Inc. ~~Welfare Benefits~~Medical Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

[Add contact name here]

ClubCorp USA, Inc.
5221 N O'Connor Blvd
Suite 300
Irving, TX 75039
(972) 888-7366

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan, except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

Claims Fiduciary: United HealthCare Services, Inc. ("UnitedHealthcare," refer to your Summary Plan Description for details on the legal entity that provides your coverage) is your Plan's Claims Fiduciary and has been delegated this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan.

Employer Identification Number (EIN): 75-2114856

Plan Number: 501

Plan Year: January 1 through December 31

Type of Plan: Health care coverage plan

Name, Business Address, and Business Telephone Number of Plan Administrator:

[Add contact name here]

ClubCorp USA, Inc.
5221 N O'Connor Blvd
Suite 300
Irving, TX 75039
(972) 888-7366

Type of Administration of the Plan: Your Plan is self-funded. Benefits are provided under an administrative contract entered into between your Plan Sponsor and the Claims Administrator. The Plan's Benefits are administered by the Plan Sponsor and the Plan Administrator. The Claims Administrator processes claims for the Plan and provides appeal services; however, the Claims Administrator and your Plan Sponsor are not responsible for any decision you or your Dependents make to receive treatment, services or supplies. The Claims Administrator and Plan Sponsor are neither liable nor responsible for the treatment, services or supplies you receive from providers.

The Plan Sponsor has selected a provider Network established by UnitedHealthcare Insurance Company

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343
952-936-1300

Person designated as Agent for Service of Legal Process: ClubCorp USA, Inc.

[Add contact name here]

ClubCorp USA, Inc.
5221 N O'Connor Blvd
Suite 300
Irving, TX 75039
(972) 888-7366

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given deference and be legally binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

Source of Contributions and Funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for service fees under the Plan. Benefits under the Plan are funded by the payment of service fees required by the Plan Sponsor.

Method of Calculating the Amount of Contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Amendment or Termination of the Plan: Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.

Dental Benefits – Delta Dental Plans

Invited offers two dental plan options through Delta Dental: a Dental Provider Organization Plan and a Dental Health Maintenance Plan. DPO stands for Dental Provider Organization.

For the DPO plan, Delta Dental contracts with a network of dentists who have agreed to charge certain fees for approved services. The DPO plan offers dental provider choice as you have the freedom to visit network and out-of-network dentists. When you visit in-network dentists, the fees for covered services will generally be lower than out-of-network dentists.

DHMO insurance plans typically cover dental services at a low cost and minimal or no copayments with a pre-selected primary care dentist or a dentist facility with multiple dentists.

Dental Provider Organization (DPO) Option

Preventive services at in-network providers generally are covered at no cost to you and include routine exams and cleanings. You pay a small deductible and coinsurance for basic and major services. For information on finding a dental provider using the Delta Dental PPO network, visits **www.deltadental.com** and click Find A Dentist.

***NEW* for 2024:** Orthodontia coverage for adults/children will be covered up to $1,500.

Scan the QR code or visit **www.deltadental.com** for more information on Delta Dental networks and plans.

Dental Health Maintenance Organization (DHMO) Option

You should consult the participating provider directory prior to enrolling.

If you decide to enroll in the DHMO Option for the first time or add new dependents under this option, you need to select a primary care dentist. You can only change your dentist once per year and you can choose a different DHMO dentist for yourself and each covered dependent.

The DHMO plan is offered in AL, AR, AZ, CA, CO, DC, FL, GA, KS, KY, LA, MD, MI, MS, NV, NY, OH, PA, SC, TN, TX, WA, WI and WV.

Plan Highlights	DPO Plan	DHMO Plan
Network	Delta Dental PPO Network	Delta Dental DHMO Network
Calendar Year Maximum Benefit	$2,000	None
Calendar Year Deductible		
Individual / Family	$50 / $150	None / None
Preventive		
Exams, Cleanings, Fluoride, X-Rays and Sealants	0%	**DHMO Benefits Schedule**
Basic Services		
Filings and Simple Extractions	20%	**DHMO Benefits Schedule**
Major Services		
Space Maintainers, Crowns, Inlays, Onlays, Endodontics, Periodontics, Bridges, Dentures, and Oral Surgery	50%	**DHMO Benefits Schedule**
Orthodontia Services		
Coverage / Lifetime Maximum per Individual	50% / $1,500 for Adults & Children	For Adults: $2,100 / For Children (up to 19): $1,150

The above information is a summary only. Please refer to your Certificate of Coverage for complete details of Plan benefits, limitations and exclusions.

Dental Plan Cost	DPO Plan	DHMO Plan
	BI-WEEKLY	BI-WEEKLY
Employee Only	$15.74	$7.23
Employee and Spouse	$33.34	$12.42
Employee and Child(ren)	$32.70	$12.50
Employee and Family	$53.01	$18.01

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Certificate of Coverage

AL13B

Provided by:
Alpha Dental of Alabama, Inc.
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703

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

deltadentalins.com

CERTIFICATE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is a Certificate of Coverage ("Certificate") for your DeltaCare USA Dental Health Care Program ("Program") provided by Alpha Dental of Alabama, Inc. ("ALPHA") The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by ALPHA.

THE CERTIFICATE CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE CERTIFICATE WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS CERTIFICATE CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

You have the right to request information about how ALPHA operates its care delivery system and an explanation of Benefits to which you are entitled under the terms of this Program.

The telephone number where you may obtain this information is 800-422-4234. You may also submit a request in writing to Delta Dental Insurance Company, Attn: Contracts Mail Stop 6F, 1130 Sanctuary Parkway, Suite 600, Alpharetta, GA 30009

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental") or other entity designated by Alpha operating as an Administrator in the state of Alabama. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Alpha. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Authorization means the process by which Alpha determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Alpha.

We, Us or Our means Alpha or the Administrator as appropriate.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:
1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);

2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children beyond the limiting age. Such dependents must be Full-Time Students and wholly dependent on you for support.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Legally adopted children (other than newborns) are eligible during and after the period of probation.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

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

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract

Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY US, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

You have the right to retain, *at your own expense*, any dentist authorized to practice dentistry in the state of Alabama.

If your assigned Contract Dentist's agreement with Alpha terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services

either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by us. All authorized Specialist Services will be paid by us less any applicable Copayments.

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

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be submitted to Alpha within 90 days of the end

of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. By statute, the DeltaCare USA provider contract contains a provision prohibiting a Contract Dentist from charging you for any sums owed by Alpha.

Except for the provisions in *Emergency Services*, if you have not received Authorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Alpha, and Alpha may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Alpha shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Alpha shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Alpha chooses, the amount of any Benefits paid by Alpha

which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Alpha or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Alpha or the Administrator, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

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

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Alpha within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Alpha shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of

receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary, in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

You have the right to complain to the Alabama Board of Dental Examiners about a Dentist's conduct pursuant to either this Program or recognized standards of ethical and professional code of conduct.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Certificate of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
   c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Alpha must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Alpha will notify the Enrollee in writing, at least 30 days in advance, that Alpha considers the dentist-patient relationships to be unsatisfactory. Alpha will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Alpha plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:
1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination

that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Alpha within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her

employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Alpha within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Alpha terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Alpha plan had such plan with the former employer not

terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Alpha plan.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999	II. PREVENTIVE	
D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	$70.00
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) .	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Alpha. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Alpha, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Alpha is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Certificate of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

DeltaCare® USA

Dental Health Care Program for Eligible Employees and Dependents

Evidence of Coverage

AR13B

If you are not provided with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
501-371-2640 or 800-852-5494

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Provided by:
Dentegra Insurance Company
560 Mission Street, Suite 1300
San Francisco, CA 94105
415-972-8300
800-422-4234

Administered by:
Delta Dental Insurance Company
Customer Service:
P.O. Box 1803
Alpharetta, GA 30023
800-422-4234

deltadentalins.com

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Dentegra Insurance Company ("Dentegra"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Dentegra.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means an entity designated by Dentegra, licensed as a Third Party Administrator in Arkansas. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Dentegra. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Authorization means the process by which Dentegra determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Dentegra.

We, Us or Our means Dentegra or the Administrator as appropriate.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:

1) spouse (unless legally separated or divorced);

2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children beyond the limiting age. Such dependents must be Full-Time Students and wholly dependent on you for support.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 90 days after the date of birth for coverage to continue beyond 90 days. Legally adopted children (other than newborns) are eligible as soon as you file a petition to adopt if you apply for coverage within 60 days of filing the petition. Benefits for adopted children terminate upon dismissal or withdrawal of the petition for adoption.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided as requested. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

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

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY US, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Dentegra terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by us. All authorized Specialist Services will be paid by us less any applicable Copayments.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments*, and

the limitations and exclusions to determine which procedures are covered under this Program.

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be submitted to Dentegra within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date and will be paid immediately upon receipt of written proof of loss. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for the provisions in *Emergency Services*, if you have not received Authorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Dentegra, and Dentegra may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Dentegra shall determine whether any

reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Dentegra shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Dentegra chooses, the amount of any Benefits paid by Dentegra which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Dentegra or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Dentegra or the Administrator, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

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

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Dentegra within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a clinical judgment in applying the terms of the Contract, Dentegra shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is

involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary, in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this

Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
   c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Dentegra must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Dentegra will notify the Enrollee in writing, at least 30 days in advance, that Dentegra considers the dentist-patient relationships to be unsatisfactory. Dentegra will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Dentegra plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:
1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination

that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Dentegra within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her

employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Dentegra within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Dentegra terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Dentegra plan had such plan with the

former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Dentegra plan.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5 or more years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	$70.00
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) .	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Dentegra. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Dentegra, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Dentegra is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LAP Tagline_CA+National_Doc_10pt_5.5x8.5_032018

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

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

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

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

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

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

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

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Combined Evidence of Coverage and Disclosure Form

AZ13B

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

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

deltadentalins.com

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is a Evidence of Coverage ("Evidence") for your DeltaCare USA Dental Health Care Program ("Program") provided by Alpha Dental of Arizona, Inc. ("ALPHA") The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by ALPHA.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE Evidence WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS Evidence CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental") or other entity designated by Alpha, operating as an Administrator in Arizona. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Alpha. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Authorization means the process by which Alpha determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

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

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Alpha.

We, Us or Our means Alpha or the Administrator as appropriate.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:
1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);
2) unmarried children from birth up to the limiting age as defined by the Client; and

3) unmarried children beyond the limiting age. Such dependents must be Full-Time Students and wholly dependent on you for support.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Adopted children (other than newborns) are eligible from and after the moment the child is placed in the physical custody of the Eligible Employee for adoption. Notice of birth, adoption or adoption placement and payment of the appropriate premium must be received within 31 days after the date of birth, adoption or adoption placement for coverage to continue beyond 31 days.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

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

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY US, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Alpha terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. Contract Dentists maintain a 24-hour emergency services system seven days a week. If you are unable to reach your Contract Dentist for Emergency Services, you should call Customer Service at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Out-of-network emergency dental care is intended to evaluate and stabilize a dental condition of recent onset, control bleeding, relieve pain and eliminate acute infection in the event you are unable to reach your Contract Dentist. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by us. All authorized Specialist Services will be paid by us less any applicable Copayments.

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

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be submitted to Alpha within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. The address for claims submission: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for the provisions in *Emergency Services*, if you have not received Authorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

Coordination of Benefits

If a person receiving dental care is an Enrollee in a prepaid dental plan and is an insured or certificate holder under an indemnity health insurance policy which provides benefits for the same treatment as a prepaid dental plan, the indemnity health insurance policy, if issued after September 15, 1989, shall pay benefits to its insured or certificate holder or the assignee therof, without regard to the existence of the prepaid dental plan.

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

The indemnity plan insurer is not obligated to pay any amount for a procedure covered without charge to the Enrollee of the prepaid

dental plan or to pay in excess of the amount of the Enrollee's copayment obligation under the prepaid dental plan. In the event that the Enrollee's obligation under the prepaid dental plan has been met, then the indemnity insurer shall remit any payments due to its insured or certificate holder.

An Enrollee shall provide to Alpha, and Alpha may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Alpha shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Alpha shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Alpha chooses, the amount of any Benefits paid by Alpha which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Alpha or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Alpha or the Administrator, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

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

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Alpha within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made

the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Alpha shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within five business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

Appeals will be made to Alpha's utilization agent, Delta Dental. Delta Dental will review these appeals based upon the terms and conditions of this Contract. The following levels of review will be available to the Enrollee:

Expedited Dental Review
Informal Reconsideration
Formal Appeal
External Independent Review

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

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;

b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Alpha must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Alpha will notify the Enrollee in writing, at least 30 days in advance, that Alpha considers the dentist-patient relationships to be unsatisfactory. Alpha will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Alpha plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:

1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Alpha within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage

for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Alpha within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Alpha terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Alpha plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Alpha plan.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999	II. PREVENTIVE	
D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	$70.00
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) .	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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 dependent adult children covered from age 19 to 26* $1,350.00

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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 dependent adult children covered from age 19 to 26*	$2,100.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide specialized services, and are referred by the assigned Contract Dentist, must be authorized by Alpha. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Alpha, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Alpha is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LAP Tagline_CA+National_Doc_10pt_5.5x8.5_032018

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

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

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

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

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

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

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

Toll Free
800-422-4234

Administered by:

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

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Combined Evidence of Coverage and Disclosure Form

CA13B

Provided by:
Delta Dental of California
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703

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

deltadentalins.com

EVIDENCE OF COVERAGE

DISCLOSURE FORM

DeltaCare® USA Dental HMO Program

This booklet is a Combined Evidence of Coverage and Disclosure Form ("EOC") for your DeltaCare USA Dental HMO Program ("Program") provided by Delta Dental of California ("Delta Dental"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Delta Dental.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. AS REQUIRED BY THE CALIFORNIA HEALTH & SAFETY CODE, THIS IS TO ADVISE YOU THAT THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY. PERSONS WITH SPECIAL HEALTHCARE NEEDS SHOULD READ THE SECTION ENTITLED "SPECIAL NEEDS".

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

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a Contract Dentist may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Customer Service at 800-422-4234 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

The telephone number where you may obtain information about Benefits is 800-422-4234.

INFORMATION CONCERNING BENEFITS UNDER THE DELTACARE USA PROGRAM

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM AND THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Professional Services	An Enrollee may be required to pay a Copayment amount for each procedure as shown in the *Description of Benefits and Copayments*, subject to the limitations and exclusions. Copayments range by category of service. Examples are as follows: Diagnostic Services No Cost - $ 5.00 Preventive Services No Cost - $ 50.00 Restorative Services No Cost - $ 355.00 Endodontic Services No Cost - $ 365.00 Periodontic Services No Cost - $ 300.00 Prosthodontic Services $10.00 - $ 365.00 Oral and Maxillofacial Surgery No Cost - $ 115.00 Orthodontic Services No Cost - $2100.00 Adjunctive General Services No Cost - $ 125.00 **NOTE:** Some services may not be covered. Certain services may be covered only if provided by specified Dentists, or may be subject to an additional charge. Limitations apply to the frequency with which some services may be obtained. For example: bitewing x-rays are limited to one series of four films in each six month period; replacement of complete dentures, crowns and bridges is limited to once in any five year period.
(D) Outpatient Services	Not Covered
(E) Hospitalization Services	Not Covered
(F) Emergency Dental Coverage	The Enrollee may receive a maximum Benefit of up to $100 per emergency for out-of-area Emergency Services.
(G) Ambulance Services	Not Covered
(H) Prescription Drug Services	Not Covered
(I) Durable Medical Equipment	Not Covered
(J) Mental Health Services	Not Covered
(K) Chemical Dependency Services	Not Covered
(L) Home Health Services	Not Covered
(M) Other	Not Covered

Each individual procedure within each category listed above, and which is covered under the Program has a specific Copayment, which is shown in the *Description of Benefits and Copayments*, in the Combined Evidence of Coverage and Disclosure Form.

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Definitions

As used in this booklet:

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

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Dental Condition means dental symptoms and/or pain that are so severe that, without immediate attention by a Dentist, they could reasonably result in any of the following:
- placing the patient's health in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part

- death

Emergency Dental Service means a dental screening, examination and evaluation by a Dentist, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Dentist, to determine if an Emergency Dental Condition exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Dental Condition, within the capability of the facility.

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

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

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

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

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

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be preauthorized in writing by Delta Dental.

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

Treatment In Progress means any single dental procedure, as defined by the CDT Code, that has been started while the Enrollee was eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not the Enrollee continues to be eligible for Benefits under the DeltaCare USA Plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established full or partial dentures for which an impression has been taken and orthodontics when bands have been placed and tooth movement has begun.

Urgent Dental Services means medically necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

We, Us or Our means Delta Dental of California or the Administrator as appropriate.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include, Primary Enrollee's Spouse (unless legally separated or divorced) and children from birth up to age 26.

Children include natural children, stepchildren, adopted children, and foster children. 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. However, the Primary Enrollee may delay coverage for young children, under the age of four (4), until the beginning of any Calendar Year immediately following said child's fourth birthday. For coverage to begin on such young children, the eligibility notice and additional

Premium payment must be received within 31 days of the beginning of the Calendar Year immediately following said child's fourth birthday.

An overage dependent child may be eligible if:
1) they are incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition;
2) they are chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 60 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a physically or mentally disabling injury, illness or condition.

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

Prepayment Fees/Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

We may cancel the Contract 30 days after written notice to the Client if monthly premiums are not paid when due. The Client will be given a 30 day grace period, which begins immediately following the last day of paid coverage, to pay the monthly premium. During that time, Delta Dental will continue to provide coverage to Enrollees. If the premium remains unpaid at the end of the 30 day grace period, the Contractholder will notify you that coverage has terminated along with the date of termination.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of

Contract Dentists furnished during the enrollment process. You can also access an online provider directory at deltadentalins.com. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO THEIR ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED IN WRITING BY DELTA DENTAL, OR FOR EMERGENCY DENTAL SERVICES AS PROVIDED IN *EMERGENCY DENTAL SERVICES*. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Delta Dental terminates, that Contract Dentist will complete (1) a partial or full denture for which final impressions have been taken, and (2) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Continuity of Care

Current Members:

You may have the right to the benefit of completion of care with your terminated Dentist for certain acute dental conditions, serious chronic dental conditions and other specified dental conditions.

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

New Members:

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

Special Needs

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

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service department at 800-422-4234.

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services

personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Dental Services

Emergency Dental Services are used for palliative relief, controlling of dental pain and/or stabilizing the patient's condition. The Enrollee's assigned Contract Dentist's facility maintains a 24 hour emergency dental services system, seven days a week. If the Enrollee is experiencing an Emergency Dental Condition, they can call 911 (where available) or obtain Emergency Dental Services from any dental provider without a referral.

After Emergency Dental Services are provided, further non-emergency treatment is usually needed. Non-emergency treatment must be obtained at the Enrollee's assigned Contract Dentist's facility.

The Enrollee is responsible for any Copayment(s) for Emergency Dental Services received. Non-covered procedures will be the Enrollee's financial responsibility and will not be paid by this Plan.

Urgent Dental Services

Inside the Service Area

An Urgent Dental Service requires prompt dental attention but is not an Emergency Dental Condition. If an Enrollee thinks that they may need Urgent Dental Services, the Enrollee can call their Contract Dentist.

Out of Area Urgent Care
If an Enrollee needs Urgent Dental Services due to an unforeseen dental condition or injury, we cover Medically Necessary dental services when prompt attention is required from an Out-of-Network Dentist if all of the following are true:

- The Enrollee receives the Urgent Dental Services from Out-of-Network Dentists while temporarily outside of the Delta Dental Service Area.
- A reasonable person would have believed that the Enrollee's health would seriously deteriorate if they delayed treatment until they returned to the Delta Dental Service Area.

Enrollees do not need prior authorization for out-of-area Urgent Dental Services. The out-of-area Urgent Dental Services an Enrollee receives from Out-of-Network Dentists are covered if the Benefits would have been covered if the Enrollee had received them from Contract Dentists.

We do not cover follow-up care from Out-of-Network Dentists after the Enrollee no longer needs Urgent Dental Services. To obtain follow-up care from a Contract Dentist, the Enrollee can call their Contract Dentist. The Enrollee is responsible for any Copayment(s) for Urgent Dental Services received.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics or pediatric dentistry must be: 1) referred by your assigned Contract Dentist; and 2) authorized by us. You pay the specified Copayment(s). (Refer to the Schedules attached to this EOC.)

If you require Specialist Services and there is no Contract Specialist to provide these services within 35 miles of your home address, your assigned Contract Dentist must receive Authorization from Delta Dental to refer you to an Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist that are not authorized by Delta Dental will not be covered. Delta Dental will respond in writing to all Authorization requests for Specialist Services within five days of receipt.

If the services of a Contract Orthodontist are needed, please refer to the Schedules attached to this EOC to determine Benefits.

Second Opinion

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

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of your condition. Requests

involving cases of an Emergency Dental Condition will be authorized or denied in a timely fashion appropriate for the nature of your condition, not to exceed 72 hours after receipt of the request, whenever possible. For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service department at 800-422 4234 or write to Delta Dental.

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

Claims for Reimbursement

Claims for covered Emergency Dental Services or preauthorized Specialist Services should be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Provider Compensation

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

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

you have not received Preauthorization for treatment from an Out-of-Network Dentist, and we fail to pay that Out-of-Network Dentist, you may be liable to that Dentist for the cost of services.

You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number shown on the back cover of this booklet.

Processing Policies

The dental care guidelines for the DeltaCare USA Program explain to Contract Dentists what services are covered under the dental Contract. Contract Dentists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist that fall under the scope of Benefits of the dental Program are provided subject to any Copayments. If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a specialist. An Enrollee may contact Delta Dental's Customer Service department at 800-422-4234 for information regarding the dental care guidelines for DeltaCare USA.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or Out-of-Network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary will be governed by the rules stated in the Contract.

If this Plan is secondary, it will pay the lesser of:

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

An Enrollee must provide to Delta Dental and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed

to administer coordination of benefits. Delta Dental will, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid will be deemed to be Benefits under the Contract. Delta Dental will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefit paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Delta Dental will provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

Quality Management Department
P.O. Box 6050
Artesia, CA 90703

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you may file a request for review (a complaint) with Delta Dental for at least 180 calendar days after receipt of the adverse determination. Delta Dental's review will take into account all information, regardless of whether such information was submitted or considered initially. The review will be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, Delta Dental will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental will

consult with a Dentist who has appropriate training and experience. If any consulting dentist is involved in the review, the identity of such consulting dentist will be available upon request.

Within 5 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you a written acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a regional dental consultant for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves an Emergency Dental Condition to a patient's dental health, Delta Dental will provide you and the California Department of Managed Health Care written notification regarding the disposition or pending status of the complaint within a timely fashinon appropriate for the nature of your condition, not to exceed 72 hours.

If you have completed Delta Dental s grievance process, or you have been involved in Delta Dental s grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care. You may file a complaint with the Department immediately if you are experiencing an Emergency Dental Condition.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **800-422-4234** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Public Policy Participation by Enrollees

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

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless Delta Dental provides notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to any continued coverage option, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be cancelled, or renewal of enrollment refused, in the following events:

1) immediately:
    a) upon loss of eligibility as described in this Evidence of Coverage; or
2) upon 30 days written notice if:
    a) the Contract is terminated or not renewed;

b) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 30-day grace period and may be reinstated during the term of this Program upon payment of any unpaid premium; or
c) Delta Dental demonstrates that the Enrollee committed fraud or an intentional misrepresentation of material fact in obtaining Benefits under the Program.

Cancellation of a Primary Enrollee's enrollment, as described above, will automatically cancel the enrollment of any of their Dependent Enrollees. Any cancellation is subject to the written notification requirements set forth in the Contract and in California law.

If you believe that enrollment has been improperly cancelled, rescinded or not renewed, you may request a review by the Director of the California Department of Managed Health Care of the State of California. Please refer to the *Enrollee Complaint Procedure* section for more information.

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.

Optional Continuation of Coverage (COBRA)

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) and the California Continuation Benefits Replacement Act (or Cal-COBRA, pertaining to employers with two to 19 employees), both require that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this Plan, *at your expense*, if certain conditions are met. The period of continued

coverage depends on the Qualifying Event and whether the Enrollee is covered under federal COBRA or Cal-COBRA.

DEFINITIONS

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

Qualified Beneficiary means:
1) Enrollees who are enrolled in the Delta Dental plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your Dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE UNDER FEDERAL COBRA

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:
1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and

2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your Dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your Dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

Under federal COBRA law only, when an employer has filed for bankruptcy under Title 11, United States Code, Benefits may be substantially reduced or eliminated for retired employees and their Dependents, or the surviving spouse of a deceased retired employee. If this Benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, they may choose to continue coverage until their death. The Primary Enrollee's Dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

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

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

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

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

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

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

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

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

ELECTION OF CONTINUED COVERAGE

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

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

Failure to provide this written notice of election to the administrator within 60 days will result in the loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to the administrator, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in the loss of the right to continue coverage and any premiums received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their Dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or Dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this Plan; or
6) entitlement to Medicare.

Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental terminates prior to the time that the continuation coverage would otherwise terminate, the employer will notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained

covered under the Delta Dental plan had such plan with the former employer not terminated. The employer will notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Delta Dental plan.

Organ and Tissue Donation

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

Non-Discrimination

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

- 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)

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 our Customer Service Center at 800-422-4234.

If you believe that Company 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:

DeltaCare USA
17871 Park Plaza Drive, Ste. 200
Cerritos, CA 90703
Telephone Number: 800-422-4234
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.

Timely Access to Care

Contract Dentists, Contract Orthodontists, and Contract Specialists have agreed waiting times to Enrollees for appointments for care will never be greater than the following time frames:

1) For emergency care, 24 hours a day, 7 day days a week;
2) For any urgent care, 72 hours for appointments consistent with the patient's individual needs;
3) For any non-urgent care, 36 business days; and
4) For any preventative services, 40 business days.

During non-business hours, the Enrollee will have access to their Contract Dentist s answering machine, answering service, cell phone or pager for guidance on what to do and who to contact if the Enrollee is calling due to an emergency or urgent care situation.

If an Enrollee calls our Plan's customer service phone number, a Customer Service Representative will answer the phone within 10 minutes during normal business hours.

Should the Enrollee need interpretation services when scheduling an appointment with any of our Contract Dentist, Contract Orthodontist and Contract Specialist offices, please call 800-422-4234 for assistance.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures D9944, D9945, D9946 (occlusal guard).
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LAP Tagline_CA+National_Doc_10pt_5.5x8.5_032018

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

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

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

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

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

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

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

Toll Free
800-422-4234

Delta Dental of California
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Evidence of Coverage

CO13B

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

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Dentegra Insurance Company ("Dentegra"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Dentegra.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental") or other entity designated by Dentegra, operating as an Administrator in the state of Colorado. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Dentegra. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or

immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Authorization means the process by which Dentegra determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Dentegra.

We, Us or Our means Dentegra or the Administrator as appropriate.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:

1) spouse (unless legally separated or divorced);
2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children beyond the limiting age. Such dependents must be Full-Time Students and wholly dependent on you for support.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Legally adopted children (other than newborns) are eligible during and after the period of probation.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

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

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY THE ADMINISTRATOR, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Dentegra terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by the Administrator. All authorized Specialist Services will be paid by us less any applicable Copayments.

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

Claims for Reimbursement

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

Claims for covered Emergency Services or authorized Specialist Services must be sent within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. Except in the absence of legal capacity, all claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Dentegra or the Administrator shall have the right and opportunity to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for the provisions in *Emergency Services*, if you have not received Authorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this

Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Dentegra, and we may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Dentegra shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. We shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as we choose, the amount of any Benefits paid by Dentegra which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Dentegra or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Dentegra or the Administrator, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

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

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Dentegra

within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, we shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary, in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due, or within the 31 day premium grace period. However the Enrollee may continue to receive Benefits during the 31-day period and may be reinstated during the term of this Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or

c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Dentegra must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Dentegra will notify the Enrollee in writing, at least 30 days in advance, that Dentegra considers the dentist-patient relationships to be unsatisfactory. Dentegra will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Entire Agreement

The Contract, the Contract application, and any attached schedules, appendices, endorsements and riders, constitute the entire agreement between Dentegra and Client. All statements made by the Client or by any persons covered shall be deemed representations and not warranties. No agent has authority to amend this Contract or waive any of its provisions. No amendment to this Contract shall be valid unless approved by an executive officer of Dentegra and evidenced by endorsements. Any amendment which reduces or eliminates coverage shall have been either requested in writing or signed by the Client.

Optional Continuation of Coverage

Both the federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) and Colorado Insurance Code: 10-16-108 (for all size groups) require that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:

1) you and/or your dependents who are enrolled in the Dentegra plan on the day before the Qualifying Event, or

2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:

1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend

coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Dentegra within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 10 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly Premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage, or 60 days from the date of the Qualifying Event, whichever is longer, to pay the initial Premium to his or her employer, which includes the Premium for each month since the loss of coverage. Failure to pay the required Premium within the 45 days will result in loss of the right to continue coverage and any Premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Dentegra within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Dentegra terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Dentegra plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified

Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Dentegra plan.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Dentegra. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the general Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Dentegra, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Dentegra is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

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

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures D9944, D9945, D9946 (occlusal guard).
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Any part of a preventive or soft tissue management program which is not a listed covered service on *Schedule A, Description of Benefits and Copayments*.
20. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
21. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Toll Free
800-422-4234

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

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Combined Evidence of Coverage and Disclosure Form

DC13B

Provided by:
Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

deltadentalins.com

EVIDENCE OF COVERAGE

DISCLOSURE FORM

DeltaCare® USA Dental Health Care Program

This booklet is a Combined Evidence of Coverage and Disclosure Form ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Delta Dental Insurance Company ("Delta Dental") in the District of Columbia. The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Delta Dental.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM, OR WHAT GROUP OF PROVIDERS, DENTAL TREATMENT MAY BE OBTAINED.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental") or other entity designated by Delta Dental, operating as an Administrator in the District of Columbia. Administrative functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or

immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

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

Specialist Services means services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be preauthorized by the Administrator.

We, Us or Our means Delta Dental or the Administrator as appropriate.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);
2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children beyond the limiting age. Such dependents must be Full-Time Students and wholly dependent on you for support.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Legally adopted children (other than newborns) are eligible during and after the period of probation.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

The dependent child is not required to reside with a parent or legal guardian who is an Enrollee.

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

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED BY THE ADMINISTRATOR, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Delta Dental terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and preauthorized by the Administrator. All preauthorized Specialist Services will be paid by us less any applicable Copayments.

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

Claims for Reimbursement

Claims for covered Emergency Services or preauthorized Specialist Services must be submitted to the Administrator within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event that we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. Except for the provisions in *Emergency Services*, if you have not received Preauthorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Delta Dental, and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an

insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Delta Dental shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefits paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Delta Dental shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

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

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Delta Dental within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is

involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary, in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Enrollee Complaint Procedure*, or the *Optional Continuation of Coverage* provision, an Eligible Employee's or

Eligible Dependent's enrollment under this Program may be cancelled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
   c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Delta Dental must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Delta Dental will notify the Enrollee in writing, at least 30 days in advance, that Delta Dental considers the dentist-patient relationships to be unsatisfactory. Delta Dental will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Delta Dental plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:
1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination

that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Delta Dental within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her

employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Delta Dental within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Delta Dental plan had such plan with

the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Delta Dental plan.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	$70.00
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) .	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide specialized services, and are referred by the assigned Contract Dentist, must be preauthorized by the Administrator. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

Toll Free
800-422-4234

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

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Certificate of Coverage

FL13B

Provided by:
Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009
800-422-4234

Delta Dental provides Benefits as a Prepaid Limited Health Service Organization as described in Chapter 636 of the Florida Statutes

deltadentalins.com

CERTIFICATE OF COVERAGE

Delta Dental Insurance Company

DeltaCare® USA Dental Health Care Program

This booklet is a Certificate of Coverage ("Certificate") for your DeltaCare USA Dental Health Care Program ("Program") provided and administered by Delta Dental Insurance Company ("Delta Dental"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Delta Dental.

THE CERTIFICATE CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE CERTIFICATE WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS CERTIFICATE CAREFULLY AND COMPLETELY.

Benefits for preexisting conditions (e.g. missing teeth) are covered under the DeltaCare USA Program. However, Benefits are not provided for dental treatment in progress at inception of eligibility in this Program. Refer to Exclusion of Benefits #13.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental") or other entity designated by Delta Dental, operating as an Administrator in the state of Florida. Administrative functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or

immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term or a period as otherwise requested by the Client and agreed to by Delta Dental.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

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

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be preauthorized by Delta Dental.

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

1) as defined and as may be required to be treated as a Spouse by the laws of the state where this Contract is issued and delivered;
2) 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
3) as may be recognized by the Contractholder.

We, Us or Our means Delta Dental or the Administrator as appropriate.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:
1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include Primary Enrollee's Spouse and unmarried dependent children from birth to age 19; dependent grandchildren until age 18 months; and unmarried dependent children from age 19 to the end of the calendar year in which they turn 25 if they are supported by the Eligible Employee and they live in the Eligible Employee's household or they are enrolled as full-time or part-time students in an accredited school.

Children include natural children, children of a covered family member, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as recognized by the Contractholder. Children/students must be dependent upon the Primary Enrollee for support and maintenance. 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.

Children who reach the limiting age are eligible if:
1) he/she is incapable of self-sustaining employment because of an intellectual or physical disability;
2) he/she is chiefly dependent on the Eligible Employee for support; and
3) proof of dependent's disability is provided. Enrollment 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/she reached the limiting age.

Dependents on active military duty are not eligible. No Eligible Dependent may be enrolled under more than one Eligible Employee. Medicare eligibility shall not affect eligibility of an Eligible Employee or Eligible Dependent.

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of

the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED BY DELTA DENTAL, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Delta Dental terminates, that Contract Dentist will complete (a) a partial or full

denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and preauthorized by Delta Dental. All preauthorized Specialist Services will be paid by us less any applicable Copayments.

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

Claims for Reimbursement

Claims for covered Emergency Services or preauthorized Specialist Services must be submitted to us within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. Except in the absence of legal capacity of the claimant, all claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist or Contract Specialist, you will not be liable to that Dentist for any sums owed by us. By statute, the DeltaCare USA provider contract contains a provision prohibiting a Contract Dentist or Contract Specialist from charging an Enrollee for any sums owed by Delta Dental.

Except for the provisions in *Emergency Services*, if you have not received Preauthorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim

determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Delta Dental, and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Delta Dental shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefits paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Informal Grievances

An Enrollee who has a grievance against Delta Dental for any matter arising out of this Contract may make an informal complaint by calling the toll-free number 800-422-4234. A grievance is not considered formal until Delta Dental receives a written complaint.

Formal Grievances

Written complaints may be addressed to:

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

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) the Enrollee must file a request for review (a complaint) with Delta Dental within one year after receipt of the adverse determination. Our review will take into account all information, regardless of

whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgement of receipt of the complaint. Certain requests may require that you be referred to a Dentist in your area for clinical evaluation of the dental services provided. We will make a determination, in writing, within 30 days of receipt of a complaint or shall provide a written explanation if additional time is required to report on the complaint. In no event will the decision on the request for review be sent more than 90 days after Delta Dental receives it.

Appeal of Decision

A review of the decision shall 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 shall undertake a full and fair review upon any request. We may require additional documents as we deem necessary in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

An Enrollee who is dissatisfied with the decision may appeal in writing to the State of Florida Office of Insurance Regulation.

The State of Florida Office of Insurance Regulation may be contacted at any time, concerning any complaint or request for assistance, by writing to 200 East Gaines St., Tallahassee, FL 32399, or by calling the Office's toll-free consumer hotline: 800-342-2762.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide 60 days notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Enrollee Complaint Procedure*, the *Optional Continuation of Coverage* provision or the *Extension of Benefits or Conversion Privilege* below, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
    a) upon loss of eligibility as described in this Certificate of Coverage; or
    b) if the premiums are not paid by or on behalf of the Enrollee on the date due, or within the 30-day premium grace period. The Enrollee may continue to receive Benefits during the 30-day grace period and may be reinstated during the term of the Contract upon payment of any unpaid premium. If coverage is not reinstated, the Enrollee will be responsible for the cost of services received during the 30-day grace period; or
    c) if the Contract is terminated or not renewed.
2) Upon 45 days written notice if:
    a) the Enrollee's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that the Enrollee's continuing participation seriously impairs the organization's ability to provide services to other Enrollees;

b) the Enrollee commits fraud or misrepresentation in applying for or presenting any claim for Benefits under this Contract;
c) the Enrollee misuses the documents provided as evidence of Benefits available under the Contract; or
d) the Enrollee furnishes incorrect or incomplete information to Delta Dental in order to fraudulently obtain services.

Prior to cancellation, Delta Dental will make every effort to resolve problems through the grievance procedures and will determine that the Enrollee's behavior is not due to the use of the services or mental illness.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Extension of Benefits

Benefits will continue to be provided for dental services provided to a patient who is totally disabled when coverage ends, if:
1) The Dentist recommends the services to the patient in writing, and the services began, while coverage was in effect.
2) The services are not for routine examinations, prophylaxis, x-rays, sealants, or orthodontic services.
3) The services are provided within 90 days after the patient's coverage ended, and the coverage did not end because the patient (or, in the case of a dependent child, the child's parent) voluntarily terminated coverage.

The extension of Benefits ends at the earlier of:
1) the end of the 90-day period in 3) above; or
2) the day the patient becomes covered under another contract which does not exclude benefits for the procedure because of an elimination period or limitations.

All limitations and exclusions in the Contract will continue to apply during the extension.

Conversion Privilege

A person who has been continuously covered under the Contract for at least three months, and who loses that coverage, may convert to individual coverage within 31 days after losing the coverage without providing evidence of insurability. The person must pay premium at individual rates.

However, a person may not convert to individual coverage if the lost coverage is replaced by similar coverage within 31 days, or if the person lost coverage because he or she:

1) did not pay any required premium or contribution;
2) committed fraud or material misrepresentation in applying for coverage;
3) willfully and knowingly misused the Contract identification or member certificate;
4) willfully and knowingly gave incorrect or incomplete information to fraudulently obtain coverage;
5) left the geographic service area and does not intend to live there in the future; or
6) acted in a way that was so disruptive, unruly, abusive, or uncooperative that continuing the coverage would prevent Delta Dental from providing proper services to that person or to any other patients. However, before Delta Dental cancels an Enrollee's coverage it will try to resolve the problem through the grievance procedure and will make sure that the person's behavior is not caused by the services provided or mental illness.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:

1) you and/or your dependents who are enrolled in the Delta Dental plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:

1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Delta Dental within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage

for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Delta Dental within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Delta Dental plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Delta Dental plan.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020, procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999	II. PREVENTIVE	
D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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 dependent adult children covered from age 19 to 25* $1,350.00

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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 dependent adult children covered from age 19 to 25*	$2,100.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

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

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances, full or partial dentures, space maintainers and crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Certificate of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Any part of a preventive or soft tissue management program which is not a listed covered service on *Schedule A, Description of Benefits and Copayments*.
20. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
21. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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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).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Toll Free
800-422-4234

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

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Combined Evidence of Coverage and Disclosure Form

GA13B

Provided by:
Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009
800-422-4234

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

deltadentalins.com

EVIDENCE OF COVERAGE

DISCLOSURE FORM

DeltaCare® USA Dental Health Care Program

This booklet is a Combined Evidence of Coverage and Disclosure Form ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Delta Dental Insrance Company ("Delta Dental"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Delta Dental.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental"), or other entity designated by Delta Dental, operating as an Administrator in the state of Georgia. Administrative functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or

immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term or a period as otherwise requested by the Client and agreed to by Delta Dental.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

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

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be preauthorized by Delta Dental.

We, Us or Our means Delta Dental or the Administrator as appropriate.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:
1) the date you are eligible for coverage;

2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);
2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children, beyond the limiting age, up to and including age 25 if they continue to be dependent on you for support and maintenance and are a Full-Time Student; or would have been a Full-Time Student if not prevented by illness or injury.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Foster and adopted children (other than newborns) are eligible from and after the moment the child is placed in the physical custody of the Eligible Employee.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

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

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire

to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED BY DELTA DENTAL, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Delta Dental terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and preauthorized by Delta Dental. All preauthorized Specialist Services will be paid by us less any applicable Copayments.

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

Claims for Reimbursement

Claims for covered Emergency Services or preauthorized Specialist Services must be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event that we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. Except for the provisions in *Emergency Services*, if you have not received Preauthorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Delta Dental, and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these

coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Delta Dental shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefits paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Delta Dental shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234 or the complaint may be addressed in writing to:

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

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Delta Dental within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within five business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Enrollee Complaint Procedure*, or the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be cancelled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;

2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due or within a 31 day grace period, provided, however, that the Enrollee may continue to receive Benefits during the 15 day period and may be reinstated during the term of this Contract upon payment of any unpaid premiums; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;

3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
   c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Delta Dental must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Delta Dental will notify the Enrollee in writing, at least 30 days in advance, that Delta Dental considers the dentist-patient relationships to be unsatisfactory. Delta Dental will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Delta Dental plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:
1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination

that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Delta Dental within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her

employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Delta Dental within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Delta Dental plan had such plan with

the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Delta Dental plan.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Toll Free
800-422-4234

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

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Evidence of Coverage

HI13B

Provided by:
Alpha Dental Programs, Inc.
1701 Shoal Creek, Suite 240
Highland Village, TX 75077

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

deltadentalins.com

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Alpha Dental Programs, Inc. ("ALPHA"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by ALPHA.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental") or other entity designated by Alpha, licensed as a Third Party Administrator in Kentucky. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Alpha. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 844-697-0581.

Authorization means the process by which Alpha determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Alpha.

We, Us or Our means Alpha or the Administrator as appropriate.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:
1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);

2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children beyond the limiting age. Such dependents must be Full-Time Students and wholly dependent on you for support.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. If additional premium is required in order to add the dependent newborn child, notice of birth and additional premium must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Legally adopted children (other than newborns) are eligible from and after the moment the Enrollee assumes legal obligation for total or partial support of the child in anticipation of adoption. If additional premium is required in order to add the dependent child, notice of placement for adoption and additional premium must be made within 31 days.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

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

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire

to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY US, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Alpha terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under the Plan, will be the responsibility of the Enrollee and not a covered benefit.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by us. All authorized Specialist Services will be paid by us less any applicable Copayments.

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

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be submitted to Alpha within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for the provisions in *Emergency Services*, if you have not received Authorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Alpha, and Alpha may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer

coordination of benefits. Alpha shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Alpha shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Alpha chooses, the amount of any Benefits paid by Alpha which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Alpha shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Alpha, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

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

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Alpha within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Alpha shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the

review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a Dentist for a clinical evaluation of the dental services provided. We will make a determination, in writing, within 60 days of receipt of a complaint or within 72 hours in any case in which delay would seriously jeopardize the Enrollee's health, seriously jeopardize the Enrollee's ability to gain maximum functioning or subject the Enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. We shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary in making such a review. We shall provide a written response to you within 60 days after receipt of the appeal and supporting documentation or in the case of an expedited appeal, 72 hours after the time of requesting the appeal. An Enrollee may request an external appeal of the decision if a request for an appeal of the determination is made to the Commissioner of Insurance within 60 days of the written determination.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
   c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Alpha must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Alpha will notify the Enrollee in writing, at least 30 days in advance, that Alpha considers the dentist-patient relationships to be unsatisfactory. Alpha will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may

be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Alpha plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:
1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Alpha within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Alpha within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Alpha terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the

period that a Qualified Beneficiary would have remained covered under the Alpha plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Alpha plan.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999	II. PREVENTIVE	
D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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 dependent adult children covered from age 19 to 26* $1,350.00

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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 dependent adult children covered from age 19 to 26*	$2,100.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Alpha. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Alpha, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Alpha is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services, except treatment of, or appliances for, newborn children with congenital defects.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

LAP Tagline_CA+National_Doc_10pt_5.5x8.5_032018

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

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

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

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

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

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

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

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Evidence of Coverage

IL13B

Provided by:
Alpha Dental Programs, Inc.
1701 Shoal Creek, Suite 240
Highland Village, TX 75077

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

deltadentalins.com

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Alpha Dental Programs, Inc. ("ALPHA"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by ALPHA.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental") or other entity designated by Alpha, licensed as a third party administrator in the state of Illinois. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Alpha. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Authorization means the process by which Alpha determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean care provided by a Dentist to treat a dental condition of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection such that the absence of immediate attention could reasonably be expected by the Enrollee to result in either: (1) placing the Enrollee's dental health in serious jeopardy, or (2) serious impairment to dental functions.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Reasonable means that an Enrollee exercises prudent judgment in determining that a dental emergency exists and makes at least one attempt to contact his/her Contract Dentist to obtain Emergency Services before seeking care from another Dentist.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Alpha.

We, Us or Our means Alpha or the Administrator as appropriate.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:
1) the date you are eligible for coverage;

2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);
2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children beyond the limiting age. Such dependents must be Full-Time Students and wholly dependent on you for support.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Adopted children (other than newborns) are eligible from and after the moment the child is placed in your physical custody for adoption, regardless of whether a final order granting adoption is ultimately issued.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

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

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire

to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY US, OR FOR EMERGENCY SERVICES AS PROVIDED UNDER *EMERGENCY SERVICES*. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Alpha terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call Customer Service at 800-422-4234 for assistance in obtaining urgent care. Benefits for Emergency Services by an out-of-network Dentist are limited to necessary care to stabilize your condition and/or provide palliative relief when you:

1) have made a Reasonable attempt to contact the Contract Dentist and the Contract Dentist is unavailable or is unable to see you within 24 hours of making contact; or
2) believe, due to trauma to the teeth, mouth or oral cavity, that your condition makes it dentally/medically inappropriate to travel to the Contract Dentist to receive Emergency Services or otherwise obtain an urgent care referral.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s); any charges over the $100.00 benefit maximum; and charges for services by a Dentist other than your Contract Dentist if the above conditions are not met.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by us. All authorized Specialist Services will be paid by us less any applicable Copayments.

If we do not have a Contract Specialist with the professional training and expertise in treating the particular dental disease or condition, or such Contract Specialist cannot be reached without unreasonable delay or travel, then we will authorize treatment to be performed by a specialist outside the network.

If the Contract Dentist receives authorization to refer you to a specialist who is not a Contract Specialist for non-emergency covered dental services, Alpha will be responsible for payment of the specialist's charges that exceed the Copayment specified in the Contract. You will only be liable for the same fees and/or Copayments that the Enrollee would pay to a Contract Specialist for the same treatment.

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be submitted to Alpha within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for the provisions in *Emergency Services*, if you have not received Authorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this

Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Alpha, and Alpha may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Alpha shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Alpha shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Alpha chooses, the amount of any Benefits paid by Alpha which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Alpha or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Alpha or the Administrator or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

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

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

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

you must file a request for review (a complaint) with Alpha within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Alpha shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary, in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

As described above, an Enrollee may request a review of any decision made by Alpha or the Administrator by contacting the Customer Service department at the number listed above for assistance with a request for review. Alpha makes every effort to provide satisfactory resolution. In the event your complaint remains unresolved, you may contact the Illinois Department of Insurance, Consumer Division or Public Services Section at 320 W. Washington Street, Springfield, Illinois 62767-0001 for further assistance.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately upon loss of eligibility as described in this Evidence of Coverage; or
2) Upon 15 days written notice if:
   a) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
   b) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of this Contract upon payment of any unpaid premium; or
   c) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or

c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Alpha must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Alpha will notify the Enrollee in writing, at least 30 days in advance, that Alpha considers the dentist-patient relationships to be unsatisfactory. Alpha will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:

1) you and/or your dependents who are enrolled in the Alpha plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:

1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Alpha within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage

for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Alpha within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Alpha terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Alpha plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Alpha plan.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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 dependent adult children covered from age 19 to 26* $1,350.00

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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 dependent adult children covered from age 19 to 26*	$2,100.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Alpha. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Alpha, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA plan. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Alpha is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

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

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

However, if the Enrollee is referred to an out-of network Dentist because Alpha does not have a Contract Dentist or Contract Specialist that can be reached without unreasonable delay or travel, the Enrollee shall only be liable for the same fees and/or Copayments that he or she would pay to a Contract Dentist or Contract Specialist for the same treatment.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with Alpha. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures D9944, D9945, D9946 (occlusal guard).
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Any part of a preventive or soft tissue management program which is not a listed covered service on *Schedule A, Description of Benefits and Copayments*.
20. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
21. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

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

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

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

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

Toll Free
800-422-4234

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

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Evidence of Coverage

KS13B

Provided by:
Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

deltadentalins.com

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Delta Dental Insurance Company ("Delta Dental"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Delta Dental.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

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

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Delta Dental.

We, Us or Our means Delta Dental Insurance Company.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:
1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);
2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children beyond the limiting age. Such dependents must be Full-Time Students and wholly dependent on you for support.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Legally adopted children (other than newborns) are eligible from the date of adoption or placement for adoption.

An unmarried dependent child may continue eligibility if:

1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

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

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will

request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY US, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Delta Dental terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides

treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by us. All authorized Specialist Services will be paid by us less any applicable Copayments.

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

Claims for Reimbursement

Delta Dental, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished for filing proofs of loss. If claim forms are not furnished within 15 days after giving notice, the claimant shall be deemed to have complied with the requirements of this Contract as to proof of loss upon submitting, within the time fixed in the Contract for filing proof of loss, written proof covering the occurrence, the character and the extent of the

loss for which claim is made. Claims payable under the Contract will be paid immediately upon receipt of written proof of such loss.

Claims for covered Emergency Services or authorized Specialist Services must be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. Except in the absence of legal capacity, all claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for the provisions in *Emergency Services*, if you have not received Authorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

No action at law or in equity shall be brought to recover on the Contract prior to 60 days after proof of loss has been filed in accordance with the requirements of the Contract. No such action shall be brought at all unless brought within five years from the expiration of the time within which proof of loss is required by the Contract.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Delta Dental, and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Delta Dental shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefits paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Delta Dental shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

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

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Delta Dental within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of

a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary, in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
   c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Delta Dental must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Delta Dental will notify the Enrollee in writing, at least 30 days in advance, that Delta Dental considers the dentist-patient relationships to be unsatisfactory. Delta Dental will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may

be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Delta Dental plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:
1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Delta Dental within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Delta Dental within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for

the balance of the period that a Qualified Beneficiary would have remained covered under the Delta Dental plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Delta Dental plan.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LAP Tagline_CA+National_Doc_10pt_5.5x8.5_032018

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

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

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

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

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

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

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

Toll Free
800-422-4234

Customer Service:

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

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Evidence of Coverage

KY13B

Provided by:
Alpha Dental Programs, Inc.
1701 Shoal Creek, Suite 240
Highland Village, TX 75077

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

deltadentalins.com

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Alpha Dental Programs, Inc. ("ALPHA"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by ALPHA.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental") or other entity designated by Alpha, licensed as a Third Party Administrator in Kentucky. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Alpha. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Authorization means the process by which Alpha determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Alpha.

We, Us or Our means Alpha or the Administrator as appropriate.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:

1) spouse (unless legally separated or divorced);

2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children beyond the limiting age. Such dependents must be Full-Time Students and wholly dependent on you for support.

Children include natural children, stepchildren, adopted children or any child for which the Eligible Employee is a court appointed guardian and foster children provided all such children are dependent on the Eligible Employee for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. If additional premium is required in order to add the dependent child, notice of birth and additional premium must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Legally adopted children (other than newborns) are eligible from and after the date the Eligible Employee files a petition for adoption or an application for appointment of guardianship.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

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

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY US, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Alpha terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

If a Dentist meets Alpha's enrollment criteria and is willing to meet the terms and conditions for participation in the DeltaCare

USA network, that Dentist has the right to become a Contract Dentist. For additional information the Dentist should contact the Department of Network Administration and Contracting at 800-801-7105.

All Dentists shall maintain the confidentiality of Enrollee dental records and treatment information in accordance with state and federal law. Neither Dentist nor associate Dentist(s) shall disclose or use confidential information for their own benefit or gain. Dentist and Associate Dentist(s) may use confidential information only to the extent necessary to perform their duties or upon express prior written permission of Alpha or the Enrollee. Dentist agrees upon the effective date of termination of his or her network agreement, to return to Alpha all confidential information in the possession of Dentist or an Associate Dentist.

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by us. All authorized Specialist Services will be paid by us less any applicable Copayments.

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

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be submitted to Alpha within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for the provisions in *Emergency Services*, if you have not received Authorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses

in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a Claim Determination Period are not more than 100 percent of total Allowable Expenses. Any Benefit Reserve will be reflected in the Client's overall specialty care cost experience and reviewed at renewal period.

"Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

"Benefit Reserve" means the savings recorded by a plan for claims paid for a covered person as a secondary plan rather than as a primary plan.

"Claim Determination Period" means a period of at least twelve (12) consecutive months, over which allowable expenses shall be compared with total benefits payable in the absence of coordination of benefits, to determine whether overinsurance exists and how much each plan will pay or provide.

An Enrollee shall provide to Alpha, and Alpha may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Alpha shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Alpha shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Alpha chooses, the amount of any Benefits paid by Alpha which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Alpha or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you, your authorized representative or a provider acting on your behalf have any complaint regarding eligibility, the denial of dental services or

claims, the policies, procedures or operations of Alpha or the Administrator or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422 4234, or the complaint may be addressed in writing to:

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

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you, your authorized representative or a provider acting on your behalf must file a request for review (a complaint) with Alpha within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you or the authorized individual or provider submitting the complaint with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Alpha shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to the individual who submitted the complaint an acknowledgment of receipt of the complaint. Certain complaints may require that the patient 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 shall provide a written explanation if additional time is required to report on the complaint.

A review of the decision shall be undertaken if a written request for an appeal of the determination is made within 60 days of the date of the written determination. We shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
    a) upon loss of eligibility as described in this Evidence of Coverage; or
    b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;

2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee within the 30 day premium grace period. You may continue to receive Benefits during the 30-day premium grace period and may be reinstated during the term of this Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
   c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Alpha must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Alpha will notify the Enrollee in writing, at least 30 days in advance, that Alpha considers the dentist-patient relationships to be unsatisfactory. Alpha will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Alpha plan on the day before the Qualifying Event, or

2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:

1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend

coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Alpha within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Alpha within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Alpha terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Alpha plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply

with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Alpha plan.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999	II. PREVENTIVE	
D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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 dependent adult children covered from age 19 to 26* $1,350.00

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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 dependent adult children covered from age 19 to 26*	$2,100.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide specialized services, and are referred by the assigned Contract Dentist, must be authorized by Alpha. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Alpha, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Alpha is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Evidence of Coverage

LA13B

Provided by:
Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

deltadentalins.com

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Delta Dental Insurance Company ("Delta Dental"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Delta Dental.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

ENROLLEES WHO SEEK TREATMENT FROM NON-DELTACARE USA DENTISTS ARE RESPONSIBLE FOR THE DIFFERENCE, IF ANY, BETWEEN THE AMOUNT DELTA DENTAL PAYS AND THE NON-DELTACARE USA DENTIST'S USUAL FEE FOR SUCH TREATMENT.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Copayment means the amount listed in Schedule A charged to an Enrollee by a Dentist for the Benefits provided under this Contract. Enrollees are responsible for payment of all Copayments at the time treatment is received.

DeltaCare USA Dentist means a Dentist who meets the criteria for, and has agreed with Delta Dental to provide services under this Contract. Not all Dentists who contract with Delta Dental to participate in a Delta Dental provider network are "DeltaCare USA Dentists." An Enrollee should confirm the Dentist's participation in the DeltaCare USA network prior to seeking treatment.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Maximum Fee Allowance means the maximum amount that Delta Dental will allow for a given 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 usual fee for a covered service.

Non-Participating Dentist or **Non-DeltaCare USA Dentist** means any Dentist other than a participating DeltaCare USA Dentist.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Single Procedure means a dental procedure that is assigned a separate CDT number.

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

Usual Fee means the fee that an individual Dentist most frequently charges for a given dental service.

We, Us or Our means Delta Dental.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);
2) children from birth up to the limiting age as defined by the Client.

Children include natural children, grandchildren in the Enrollee's legal custody and residing with the Enrollee, stepchildren, adopted children and foster children. Newborn children (including newborn adopted children) are covered from and after the moment of birth. If additional premium is required in order to add the dependent newborn child, notice of birth and additional premium must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Legally adopted children (other than newborns) are eligible from and after the moment the child is placed in the physical custody of the Eligible Employee for adoption. Any child who is placed in the home of an Enrollee following execution of an act of voluntary surrender in favor of the Enrollee or the Enrollee's legal representative shall be considered a dependent child of the Enrollee effective on the date on which the act of voluntary surrender becomes irrevocable.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

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

An Enrollee has the right to maintain coverage under this Contract at the time he or she enters service in the uniformed services by furnishing the Applicant with sums equal to that which would have been deducted from his or her compensation for such coverage. Upon timely receipt of the Enrollee's contributions required by the Contract, the Applicant shall provide Delta Dental with those contributions plus an amount equal to what the Applicant would have contributed during the period of service in the uniformed

services. The Enrollee shall notify the Applicant of his or her election to continue coverage at the time he or she enters service in the uniformed services.

An Enrollee who leaves employment to perform service in the uniformed services and who reapplies for coverage after release shall be reinstated, including all of his family members and dependents previously covered, without any clause or restriction because of a preexisting condition. Any Dependent Enrollee who is called to service in the uniformed services and whose coverage under this Contract is not maintained during such service, after release and upon application, shall be reinstated without any clause or restriction because of a preexisting condition.

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Program

Delta Dental offers a choice of selecting a Dentist from our panel of DeltaCare USA Dentists, or you may choose a Non-DeltaCare USA Dentist. A list of DeltaCare USA Dentists can be obtained by accessing the DeltaCare USA Dentist Directory at deltadentalins.com. Dentists are regularly added to the network. You are responsible for verifying whether the treating Dentist is a DeltaCare USA Dentist. To confirm a Dentist's participation in the DeltaCare USA network, you should contact the Customer Service department at 800-422-4234.

DeltaCare USA Dentist

Receiving treatment from a DeltaCare USA 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 Delta Dental and the DeltaCare USA Dentist.

Non-DeltaCare USA Dentist
If a Dentist is a Non-DeltaCare USA Dentist, the amount charged to you may be greater than what is accepted by DeltaCare USA Dentists. Non-DeltaCare USA Dentists can bill you the difference between the Dentist's usual fee and the amount paid by Delta Dental.

Additional advantages of using a DeltaCare USA Dentist:
The DeltaCare USA Dentist must accept assignment of Benefits, meaning DeltaCare USA Dentists will be paid directly by Delta Dental after payment of the Copayment. You do not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement. A Non-DeltaCare USA Dentist may require payment of all charges at the time services are received.

The DeltaCare USA Dentist will complete the dental Claim Form and submit it to us for reimbursement.

Benefits, Limitations and Exclusions

All approved claims for Benefits will be paid by Delta Dental less any applicable Copayments as listed in *Schedule A*. You are responsible for the Copayment amount for each covered procedure (see *Schedule A*).

Subject to the limitations and exclusions in *Schedule B*, we will pay for each of the procedures listed as Benefits on *Schedule A*, the fee actually charged or the Maximum Fee Allowance, whichever is lower, less the Copayment. Any procedure not listed on *Schedule A* is not a covered Benefit under this contract. For Covered services provided by a DeltaCare USA Dentist, Delta Dental will pay the DeltaCare USA Dentist directly. For covered services provided by a Non-DeltaCare USA Dentist, Delta Dental will pay the Enrollee, unless benefits have been assigned to the Dentist.

A Dentist may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services.

Upon termination of a DeltaCare USA Dentist's agreement, we shall be liable for Benefits for the completion of treatment for Single Procedures begun prior to the termination of the agreement. The terminating DeltaCare USA Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of

root canals in progress and delivery of crowns when teeth have been prepared).

If for any reason the DeltaCare USA Dentist is unable to complete treatment, we shall make reasonable and appropriate provisions for the completion of such treatment by another DeltaCare USA Dentist.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

The Enrollee should contact a Dentist for Emergency Services for covered dental procedures whenever possible. If the Enrollee is unable to reach a Dentist for Emergency Services, the Enrollee should call Customer Service at 800-422-4234 for assistance in obtaining urgent care.

Once we receive your claim, we will reimburse you subject to the terms and conditions of your DeltaCare USA coverage. Reimbursement is based on the out-of-network benefit provided through your group plan. As with any dental plan, this reimbursement may not cover the entire cost of the treatment rendered.

Claims for Reimbursement

Claims for covered Emergency Services, Specialist Services or treatment by a Non-DeltaCare USA Dentist must be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. Except in the absence of legal capacity, all claims must be received within one year of the treatment date. The address for claims submission is: Delta Dental Insurance Company, P.O. Box 1810, Alpharetta, GA 30023.

Upon receipt of a notice of claim, we will furnish to you such forms as are usually furnished for filing proofs of loss. If claim forms are not furnished within 15 days after the giving of notice, you

shall be deemed to have complied with the requirements of this contract as to proof of loss upon submitting, within the time fixed in the contract for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

We shall have the right and opportunity to examine the person of the individual for whom claim is made when and so often as we may reasonably require during the pendency of claim under the policy.

No action at law or in equity shall be brought to recover on the Contract prior to 60 days after proof of loss has been filed in accordance with the requirements of the Contract. No such action shall be brought at all unless brought within one year from the expiration of the time within which proof of loss is required by the Contract. If any limitation of this policy with respect to giving notice of claim, furnishing proof of loss, or bringing any action on this policy is less than that permitted by law of the state, district or territory in which the insured resides at the time this policy is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

Benefits payable under this Contract will be paid immediately, or within 30 days, upon receipt of written proof of loss, as described above. In the event Delta Dental fails to pay a Dentist, the Enrollee will not be liable to that Dentist for any sums owed by Delta Dental.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or Non-DeltaCare USA Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Delta Dental, and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Delta Dental shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefits paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Delta Dental shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the quality of dental services performed by a DeltaCare USA Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

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

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Delta Dental within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of

a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary, in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of Single Procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a DeltaCare USA Dentist's facility;
2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Delta Dental plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:
1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination

that the disabled individual is no longer disabled. You must notify your employer within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Delta Dental within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss

of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Delta Dental within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Delta Dental plan had such plan with the former employer not terminated. The employer shall notify the

successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Delta Dental plan.

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. **Enrollees should discuss all treatment options with their Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE COPAYMENTS
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost

D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999	II. PREVENTIVE	
D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the 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	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	$70.00
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) .	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by a Dentist, the Enrollee pays the specified Copayment. Enrollees who seek treatment from Non-DeltaCare USA Dentists are responsible for the difference, if any, between the amount Delta Dental pays and the Non-DeltaCare USA Dentist's usual fee for such treatment.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the general Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by 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 seven. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Orthodontist's usual fee for the treatment plan. A DeltaCare USA Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the DeltaCare USA Orthodontist as arranged. A Non-DeltaCare USA Orthodontist will make payment arrangements directly with the Enrollee.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

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

12. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
13. Lost, stolen or broken orthodontic appliances.
14. Changes in orthodontic treatment necessitated by accident of any kind.
15. Myofunctional and parafunctional appliances and/or therapies.
16. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
17. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
18. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
19. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

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

Toll Free
800-422-4234

Provided by:

Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Combined Evidence of Coverage and Disclosure Form

MD13B

Provided by:
ALPHA Dental Programs, Inc.
1701 Shoal Creek, Suite 240
Highland Village, TX 75077

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

deltadentalins.com

EVIDENCE OF COVERAGE

DISCLOSURE FORM

DeltaCare® USA Dental Health Care Program

This booklet is a Combined Evidence of Coverage and Disclosure Form ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by ALPHA Dental Programs, Inc. ("ALPHA"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by ALPHA.

This EOC describes the provisions of the Contract between your group and ALPHA. This EOC provides coverage for dental services and Benefits as a Dental Plan Organization in accordance with the terms and conditions specified in the Contract.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental"), or other entity designated by Alpha, operating as an Administrator in the state of Maryland. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Alpha. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Authorization means the process by which the Administrator determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Out-of-Network means treatment by a Dentist who has not signed an agreement with Alpha to provide Benefits under the terms of the Contract.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by the Administrator.

We, Us or Our means Alpha or the Administrator, as appropriate.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:
1) the date you are eligible for coverage;

2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);
2) unmarried children from birth up to age 19; and
3) unmarried children from age 19 to age 23. Such dependents must be Full-Time Students and wholly dependent on you for support.

Eligible children include natural children, stepchildren, adopted children and foster children. Coverage is also extended to any child who is recognized under a Qualified Medical Child Support Order (QMCSO). Documentation of the above must be furnished upon request by Alpha. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Legally adopted children (other than newborns) are eligible during and after the period of probation.

If you are subject to a court order to provide coverage for a dependent child, you may enroll such child at any time regardless of any enrollment period restrictions. If you do not elect dependent coverage for this dependent child, we will allow the noninsuring parent, child support enforcement agency or Department of Health and Mental Hygiene to apply for enrollment on behalf of the child. We will enroll you (if you are not already covered under the plan) and the dependent child within 20 business days after receipt of a medical support notice from your employer regardless of any enrollment period restrictions.

Coverage for a child covered by a medical support order will remain in effect unless written evidence is provided to us that:
1) the order is no longer in effect;
2) the child has been, or will be enrolled under other reasonable dental insurance coverage that will take effect on or before the effective date of the termination;
3) the employer has eliminated dependent coverage for all of its employees; or
4) you are no longer eligible for coverage, except that you may then elect continuation coverage for the child under COBRA, if applicable.

An unmarried dependent child may continue eligibility if:

1) he or she is incapable of self-support because of mental illness, a developmental disability, mental retardation or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability or retardation is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a physical or mental incapacity that began before he or she reached the limiting age. The dependent child is not required to reside with a parent or legal guardian who is an Enrollee.

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

Premiums

This Program requires premiums to be paid to the Administrator. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to the Administrator except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Program - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, the Administrator will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in

Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY THE ADMINISTRATOR, OR FOR EMERGENCY SERVICES REQUIRED DURING NON-BUSINESS HOURS WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY OR WHEN THE ENROLLEE IS UNABLE TO REACH THEIR CONTRACT DENTIST. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM, WITH THE FOLLOWING EXCEPTION:

If during the term of the Contract none of the Contract Dentists can render necessary care and treatment to the Enrollee due to circumstances not reasonably within the control of Alpha or the Administrator, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, or the disability of a significant number of the Contract Dentists, then the Enrollee may seek treatment from an independent licensed Dentist of his/her own choosing. The Administrator will pay the Enrollee for the expenses incurred for the dental services with the following limitations: the Administrator will pay the Enrollee for services which are listed in the *Description of Benefits and Copayments*, as No Cost, to the extent that such fees are reasonable and customary for Dentists in the same geographic area; the Administrator will also pay the Enrollee for those services listed in the *Description of Benefits and Copayments* for which there is a Copayment, to the extent that the reasonable and customary fees for such services exceed the Copayment for such services provided under this Program. The Enrollee may be required to give written proof of loss. Alpha and the Administrator agree to be subject to the jurisdiction of the Maryland Insurance Commissioner in any determination of the impossibility of providing services by Contract Dentists.

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. The Administrator relies on the professional judgment of the general Dentist to diagnose the appropriate efficient and prudent solution to your dental needs based on the plan Benefits. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services for covered dental procedures whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours, or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per Enrollee, per emergency. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum. Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be authorized by Alpha or obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics or pediatric dentistry must be referred by the assigned Contract Dentist and authorized by the Administrator. All authorized

Specialist Services will be paid by us less any applicable Copayments.

We will authorize continuing care from a specialist if your Contract Dentist determines that you have a life-threatening, degenerative, chronic or disabling dental condition or dental disease that requires continuing care from a specialist. If we do not have a Contract Specialist with the professional training and expertise in treating the particular dental disease or condition or such Contract Specialist cannot be reached without unreasonable delay or travel, then we will authorize treatment to be performed by a specialist outside the network.

If the assigned Contract Dentist refers you to a specialist who is not a Contract Specialist for covered dental services, we will be responsible for payment of the specialist's charges that exceed the Copayment specified in the Contract. You will only be liable for the same fees and/or Copayments that you would pay to a Contract Specialist for the same treatment.

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

Services provided by a health care professional not listed within this section are not covered.

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be submitted to the Administrator within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. Except in the absence of legal capacity of the claimant, all claims must be received within one year from the time proof is otherwise required. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist or Contract Specialist, you will not be liable to that Dentist for any sums owed by us. Except for the provisions in *Emergency Services*, if you have received unauthorized treatment from an Out-of-Network Dentist, you will be liable to that Dentist for the cost of services. For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

If you are treated by an Out-of-Network Dentist for:

1) an emergency (subject to the *Emergency Services* provisions described above); or
2) specialized dental care and are referred to an Out-of-Network specialist because the Administrator does not have a Contract Specialist with the professional training or expertise in treating that particular dental disease or condition; or
3) specialized dental care and are referred to an Out-of-Network specialist because no Contract Specialist is available to provide the required services without unreasonable delay or travel; then you shall only be liable for the same fees and/or Copayments that you would pay to a Contract Dentist for the same treatment. These Copayments can be found in *Schedule A*.

We will provide a noninsuring parent with membership cards, claim forms and any other information necessary for a child covered by a medical support order to receive benefits under this Program. If a non-insuring parent incurs expenses for covered Emergency Services or authorized Specialist Services provided to this child, we will process claims for such services and make payment to the noninsuring parent, health care provider or Department of Health and Mental Hygiene as appropriate.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or Out-of-Network Dentists are coordinated with any similar benefits provided by any other group dental insurance policy or any group dental benefits program.

The determination of which policy or program is primary shall be governed by the following rules:

1) The policy or program covering the Enrollee as other than a dependent shall be primary over the policy or program covering the Enrollee as a dependent.
2) The policy or program covering a child as a dependent of a parent whose birthday occurs earlier in a calendar year shall be primary over the policy or program covering a child as a dependent of a parent whose birthday occurs later in a calendar year (except for a dependent child whose parents are separated or divorced as described in 3) below). If both parents have the same birthday, the plan that covered either of the parents longer

is primary. However, if the other policy or program does not have this rule 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.

3) In the case of a dependent child whose parents are legally separated or divorced:
   a) If the parent with custody has not remarried, the policy or program covering the child as a dependent of the parent with custody shall be primary over the policy or program covering the child as a dependent of the parent without custody.
   b) If the parent with custody has remarried, the policy or program covering the child as a dependent of the parent with custody shall be primary over the policy or program covering the child as a dependent of the step-parent, and the policy or program covering the child as a dependent of the step-parent shall be primary over the policy or program covering the child as a dependent of the parent without custody.
   c) If there is a court decree that establishes financial responsibility for dental services which are Benefits under this Program, and if the plan with responsibility for payment has actual knowledge of the existence of the court decree, notwithstanding 3) a) and b), the policy or program covering the child as a dependent of the parent with such financial responsibility shall be primary over any other policy or program covering the child.
4) If the primary policy or program cannot be determined by the rules described in 1), 2) or 3), the policy or program which has covered the Enrollee for a longer period of time shall be primary, with the following exception: A policy or program covering the Enrollee as a laid-off or retired employee or the dependent of a laid-off or retired employee shall not be primary under this rule 4) over a policy or program covering the Enrollee as an employee or the dependent of an employee. However, if the provisions of the other policy or program do not include this exception, which results in benefits under neither being primary, then this exception shall not apply.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

The difference between the Benefit payments that this plan would have paid had it been the primary plan, and the Benefit payments that it actually paid or provided shall be recorded as a Benefit reserve for the covered person and used by this plan to pay any Allowable Expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:

1) determine its obligation to pay or provide Benefits under its Contract;
2) determine whether a Benefit reserve has been recorded for the covered person, and
3) determine whether there are any unpaid Allowable Expenses during that claims determination period.

If there is a Benefit reserve, the secondary plan will use the covered person's Benefit reserve to pay up to 100% of the total Allowable Expenses incurred during the claim determination period. At the end of the claims determination period, the Benefit reserve returns to zero. A new Benefit reserve must be created for each new claim determination period.

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, Benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

An Enrollee shall provide to the Administrator and the Administrator may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. The Administrator will, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement will be deemed to be Benefits under this Program. The Administrator will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as it chooses, the amount of any Benefits paid by the Administrator which exceeds its obligations under these coordination of benefit provisions.

Inquiry and Appeal Procedure

The following definitions apply to the Inquiry and Appeal Procedure.

"Appeal" means a protest filed by an Enrollee, an Enrollee's representative or a health care provider with the Administrator under its internal Appeal process regarding a Coverage Decision concerning an Enrollee.

"Appeal Decision" means a final determination by the Administrator that arises from an Appeal filed with the Administrator under its Appeal process regarding a Coverage Decision concerning an Enrollee.

"Coverage Decision" means:
1) an initial determination by the Administrator that results in non-coverage of a health care service;
2) a determination by the Administrator that an Enrollee is not eligible for coverage under the Contract; or
3) any determination by the Administrator that results in the rescission of an Enrollee's coverage under the Contract.

"Urgent Medical Condition" means a condition that satisfies either of the following:
1) a medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of a carrier, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
   a) placing the member's life or health in serious jeopardy;
   b) the inability of the member to regain maximum function;
   c) serious impairment to bodily function;
   d) serious dysfunction of any bodily organ or part; or
   e) the member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others; or
2) a medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

We rely upon the professional judgment of the Contract Dentists to determine the appropriate treatment required for a patient and we will make Coverage Decisions by reviewing claims to determine whether the rendered services are covered under the terms of the Contract. We will notify you and your representative, if any of our Coverage Decisions within 30 calendar days after the Coverage Decision has been made. Notice of the Coverage Decision will include the following information: 1) the reason for the decision; 2) information on how to Appeal the Coverage Decision; 3) a statement

that you, your representative or the Dentist acting on your behalf, may file a complaint with the Maryland Insurance Commissioner without first filing an Appeal if the Coverage Decision involves an urgent medical condition for which care has not been rendered; 4) the address, telephone number and facsimile number of the Maryland Insurance Commissioner; 5) a statement explaining that the Health Advocacy Unit is available to assist you or your representative in both mediating and filing an Appeal under our Inquiry and Appeal Procedure; and 6)the address, telephone number, facsimile number and email address of the Health Advocacy Unit.

You may request a second opinion if you disagree with or question the Contract Dentist's diagnosis and/or proposed treatment plan. We may also request that you obtain a second opinion to verify the appropriate application of Benefits. Second opinions will be provided at another Contract Dentist facility, unless otherwise authorized by our dental consultant. You may call the Customer Service department at 800-422-4234 to request a second opinion.

We will provide notification if any claims for dental services are not covered Benefits, stating the specific contractual reason or reasons for the determination. Any questions or concerns regarding our determination of eligibility, or our policies, procedures or operations, may be addressed to the Customer Service department at 800-422 4234. If you, your representative or the Dentist acting on your behalf want to appeal the Coverage Decision or to complain about the quality of dental services performed by a Contract Dentist, you, your representative or your Dentist may call the Customer Service department at 800-422 4234 or the appeal may be addressed in writing to:

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

Written communications must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location. Processing will generally not begin until the Administrator receives all the necessary requested information.

For Appeals involving an adverse Coverage Decision (e.g. a denial, modification or termination of a requested benefit or claim) you, your representative or the Dentist acting on your behalf must file a

request for review (an Appeal) with us within at least 180 days after receipt of the adverse decision. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original Coverage Decision, nor the subordinate of such individual. Upon request and free of charge, we will provide you or your representative with copies of any pertinent documents that are relevant to the claim, a copy of any internal rule, guideline, protocol, and/or explanation of the information relied upon in making the Coverage Decision. While Alpha does not base its Coverage Decisions in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, if you feel that these situations played a part in the review, then, we shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within five business days of the receipt of any Appeal, including adverse Coverage Decisions as described above, a quality management coordinator will forward to you an acknowledgement of receipt of the Appeal. We will make a determination, in writing, within 30 days of receipt of an Appeal or shall provide a written explanation if additional time is required to report on the Appeal. A final decision will always be made within 60 business days.

The written Appeal Decision will include 1) a statement of the specific factual basis and/or Contract provision used to make the Appeal Decision; 2) the address, telephone number and facsimile of the Maryland Insurance Commissioner; 3) a statement that you, your representative or the Dentist acting on your behalf, have the right to file a complaint with the Maryland Insurance Commissioner within four months after receipt of the Appeal determination 4) a statement that the Health Advocacy Unit is available to assist you, your representative or the Dentist acting on your behalf in filing a complaint.with the Commissioner; and 5) the address, telephone number, facsimile number and electronic mail address of the Health Advocacy Unit.

If a complaint is filed with the Maryland Insurance Commissioner, it must be filed within four months after the date of receipt of our determination. You must exhaust our appeal procedure before filing with the Maryland Insurance Commissioner regarding the coverage decision.

However, if your complaint concerns any of the following, you do not need to exhaust the appeal procedure before contacting the Maryland Insurance Commissioner:

1) an urgent medical condition for which care has not been rendered, or
2) a concern regarding the quality of care received.

The Maryland Insurance Commissioner may be contacted at:

Maryland Insurance Administration
Attention: Life/Health Complaint Unit
200 Saint Paul Place
Baltimore, Maryland 21202-2004
410-468-2244
410-468-2260 Fax

Complaints to the Maryland Insurance Administration must be in writing. Include your name, address, daytime and evening telephone numbers, as well as the reason for your complaint and copies of any materials that are important to your complaint. When filing a complaint with the Commissioner, you or your legally authorized designee will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the complaint.

The Maryland Health Advocacy Unit is available to assist you or your representative in both mediating and filing an appeal under Alpha's internal appeal process or in filing a complaint with the Maryland Insurance Administration. The Health Advocacy Unit can be reached at:

Maryland Health Advocacy Unit
Consumer Protection Division
200 St. Paul Place
Baltimore, MD 21202
410-528-1840
410-576-6571 (fax)
heau@oag.state.md.us

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under

section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

We will not engage in any retaliatory action (including termination or refusal to renew a Contract) against a Client, an Enrollee, or a Dentist (on behalf of an Enrollee) for filing a complaint with the Maryland Insurance Administration.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless Alpha provides 45 days notice of a change in premiums or Benefits, after they have been in effect for at least 12 months, and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. Alpha is not obligated to continue to provide Benefits to any such person in such event, except for the following situations:

Alpha will continue to provide Benefits for treatment in progress (less any applicable Copayment) if the treatment:

1) began before the date coverage terminates, and
2) requires two or more visits on separate days to the assigned Contract Dentist's facility.

Benefits will cease 90 days after termination of coverage.

If you or your dependents are receiving orthodontic treatment at the time of termination, Alpha will continue to provide orthodontic Benefits for:

1) 60 days if you are making monthly payments to your Contract Orthodontist, or
2) until the later of 60 days or the end of the quarter in progress, if you are making quarterly payments to your Contract Orthodontist.

At the end of 60 days (or at the end of the quarter), the Enrollee's obligation shall increase to a maximum of the Contract Orthodontist's usual fee for Enrollees and covered dependents to age 19 and the Contract Orthodontist's usual fee for Enrollees and covered dependents over age 19.

The Contract Orthodontist will prorate the amount over the number of months remaining in the initial 24 months of treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

If a Contract Dentist, or Contract Orthodontist is aware that this Program has terminated, the Contract Dentist, or Contract Orthodontist shall inform any previously enrolled persons who visit his/her dental office of the termination and of all charges for scheduled dental services before they are performed.

Cancellation of Enrollment

Subject to any continued coverage option, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) immediately:
    a) upon loss of eligibility as described in this Evidence of Coverage; or
    b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) upon 15 days written notice if:
    a) the premiums are not paid by or on behalf of the Enrollee on the date due, or within the 31 day premium grace period. However the Enrollee may continue to receive Benefits during the 31-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium; or
    b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) upon 30 days written notice if:
    a) the Contract is terminated or not renewed;
    b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
    c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. The Administrator must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist.

If the Enrollee establishes a history of unsatisfactory relationships, the Administrator will notify the Enrollee in writing, at least 30 days in advance, that Alpha considers the dentist-patient relationships to be unsatisfactory. The Administrator will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Contestability

The Contract may not be contested by Alpha, except for nonpayment of premiums, after it has been in force for 2 years from the effective date. Absent fraud, each statement made by an applicant, group contract holder, or Enrollee is considered to be a representation and not a warranty. A statement made to effectuate coverage may not be used to avoid the coverage or reduce Benefits under the Contract unless: 1) the statement is contained in a written instrument signed by the group contract holder or Enrollee, and 2) a copy of the statement is given to the group contract holder or Enrollee.

Legal Actions

An action at law or in equity may not be brought to recover on the Contract before the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Contract or after the expiration of 3 years after the written proof of loss is required to be furnished.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Alpha plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:
1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination

that the disabled individual is no longer disabled. You must notify your employer within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after the filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Alpha within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss

of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Alpha within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Alpha terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Alpha plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing

of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Alpha plan.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *2 D1110, D1120 or D4346 per calendar year*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the calendar year)*	$45.00
D1120	Prophylaxis *cleaning* - child - *2 D1110, D1120 or D4346 per calendar year*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the calendar year)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 2 D1206 or D1208 per calendar year*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 2 D1206 or D1208 per calendar year*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 2 per calendar year*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *2 D1110, D1120 or D4346 per calendar year*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by the Administrator. The Enrollee pays the Copayment specified for such services.

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 the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a contract pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Alpha, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination the Enrollee is receiving orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

   If an Enrollee is receiving ongoing orthodontic treatment at the time of termination, Alpha will continue to provide orthodontic Benefits for:

   - 60 days if the Enrollee is making monthly payments to the Contract Orthodontist, or
   - until the later of 60 days or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

At the end of 60 days (or at the end of the quarter), the Enrollee's obligation will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount over the number of months remaining in the initial 24 months of treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Alpha is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

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:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975, (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the one-time orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures D9944, D9945, D9946 (occlusal guard).
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Specialist or orthodontic treatment resulting from a prohibited referral. A prohibited referral is when the Contract Dentist directs an Enrollee to seek specialist or orthodontic care from another dental facility where a) the Contract Dentist owns a beneficial interest in the practice; b) the Contract Dentist's immediate family owns a beneficial interest of 3 percent or greater in the practice; or c) the Contract Dentist, the Contract Dentist's immediate family or a combination of the Contract Dentist and his or her immediate family has a compensation arrangement with the practice.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LAP Tagline_CA+National_Doc_10pt_5.5x8.5_032018

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

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

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

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

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

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

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

Toll Free
800-422-4234

Administrator:

Delta Dental Insurance Company

Attn: Customer Service
P.O. Box 1803
Alpharetta, GA 30023

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Evidence of Coverage

MI13B

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

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Dentegra Insurance Company ("Dentegra"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Dentegra.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental") or other entity designated by Dentegra, operating as an Administrator in Michigan. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Dentegra. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Authorization means the process by which Dentegra determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Dentegra.

We, Us or Our means Dentegra or the Administrator as appropriate.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:
1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);

2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children beyond the limiting age. Such dependents must be Full-Time Students and wholly dependent on you for support.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. If additional premium is required in order to add the dependent newborn child, notice of birth and additional premium must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Legally adopted children (other than newborns) are eligible during and after the period of probation.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

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

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY US, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Dentegra terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by us. All authorized Specialist Services will be paid by us less any applicable Copayments.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments*, and

the limitations and exclusions to determine which procedures are covered under this Program.

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be submitted to Dentegra within 90 days of the end of treatment. Notice given by you or on your behalf at P.O. Box 1810, Alpharetta, GA 30023, or to any authorized Dentegra agent, with information sufficient to identify you, shall be deemed notice to Dentegra. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. Except in the absence of legal capacity, all claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

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

Benefits payable under this Contract will be paid immediately upon receipt of written proof of loss, as described above. In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for the provisions in *Emergency Services*, if you have not received Authorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

No claim for loss incurred commencing after three years from the date of issue of this Contract shall 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 had existed prior to the effective date of coverage of this Contract.

No action at law or in equity shall be brought to recover on the Contract prior to 60 days after proof of loss has been filed in accordance with the requirements of the Contract. No such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the

Contract. If any limitation of this Contract with respect to giving notice of claim, furnishing proof of loss, or bringing any action on this Contract is less than that permitted by law of the state, district or territory in which the insured resides at the time this Contract is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Dentegra, and Dentegra may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Dentegra shall determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Dentegra shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Dentegra chooses, the amount of any Benefits paid by Dentegra which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Dentegra or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the

policies, procedures or operations of Dentegra or the Administrator, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

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

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Dentegra within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a clinical judgment in applying the terms of the Contract, Dentegra shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. You may submit supporting documentation as an appeal or appear before a designated committee. We may require additional

documents, as we deem necessary in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If you have completed the internal grievance process (described above) and feel that the grievance has not been satisfactorily resolved, you have the right to file a request for an external review of an adverse determination. The external review process will provide an impartial review of medical decisions made by a health plan. Requests for external review must be made within 60 days after you receive an adverse determination and should be sent in writing to the Commissioner of Insurance at: Michigan Department of Labor & Economic Growth, OFIS Health Plans Division - Appeals Section, P.O. Box 30220, Lansing, MI 48909-7720, 877-999-6442.

In order to file a request for an external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. For additional information regarding external review and the Patient's Right to Independent Review Act, you may check the Department's website at www.michigan.gov/cis and click on Financial and Insurance Services.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) Upon 31 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 31-day period and may be reinstated during the term of this Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
   c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Dentegra must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Dentegra will notify the Enrollee in writing, at least 30 days in advance, that Dentegra considers the dentist-patient relationships to be unsatisfactory. Dentegra will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may

be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Dentegra plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:
1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Dentegra within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Dentegra within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Dentegra terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for

the balance of the period that a Qualified Beneficiary would have remained covered under the Dentegra plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Dentegra plan.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999	II. PREVENTIVE	
D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5 or more years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Dentegra. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Dentegra, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Dentegra is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

Toll Free
800-422-4234

Administered by:

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

DeltaCare® USA

Dental Health Care Program for Eligible Employees and Dependents

Evidence of Coverage

NC13B

THE CONTRACT PROVIDES DENTAL BENEFITS ONLY. READ THIS EOC CAREFULLY AND COMPLETELY.

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

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Dentegra Insurance Company ("Dentegra"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Dentegra.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

ENROLLEES WHO SEEK TREATMENT FROM NON-DELTACARE USA DENTISTS ARE RESPONSIBLE FOR THE DIFFERENCE, IF ANY, BETWEEN THE AMOUNT DENTEGRA PAYS AND THE NON-DELTACARE USA DENTIST'S USUAL FEE FOR SUCH TREATMENT.

The telephone number where you may obtain information about Benefits is 800-422-4234.

Important Cancellation Information – Please Read the Provisions Entitled, "Renewal and Termination of Benefits" and "Cancellation of Enrollment", found on Page 11.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental") or other entity designated by Dentegra, operating as an Administrator in North Carolina. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Dentegra. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Copayment means the amount listed in *Schedule A* paid by an Enrollee to a Dentist for the Benefits provided under this Program. Enrollees are responsible for payment of all Copayments at the time treatment is received.

DeltaCare USA Dentist means a Dentist who has agreed to provide services at pre-negotiated rates. Not all Dentists who contract with a Delta Dental plan are "DeltaCare USA Dentists." An Enrollee should confirm the Dentist's participation in the DeltaCare USA network on Dentegra's website (deltadentalins.com) prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Maximum Fee Allowance means the maximum amount that Dentegra will allow for a given 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 usual fee for a covered service.

Non-DeltaCare USA Dentist means any Dentist other than a participating DeltaCare USA Dentist.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Single Procedure means a dental procedure that is assigned a separate CDT number.

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

We, Us or Our means Dentegra or the Administrator as appropriate.

Eligibility for Benefits

Eligible Employees and Eligible Dependents receive Benefits as soon as they are enrolled in the Program. All new employees or new members, as the case may be, in the groups or classes eligible for coverage as specified in the Contract must be added to such groups or classes for which they are respectively eligible. Subject to cancellation as provided under this Program, enrollment of Eligible Employees and Eligible Dependents is for a minimum period of one year.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:
1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);
2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children beyond the limiting age. Such dependents must be Full-Time Students and wholly dependent on you for support.

Children include:
1) natural children;
2) stepchildren;
3) adopted children; and
4) foster children

All such children must be dependent on the Eligible Employee for support.

Newborn children (including newborn adopted or foster children) are covered from and after the moment of birth. If additional premium is required in order to add the dependent newborn child, notice of birth and additional premium must be received within 31 days after the date of birth for coverage to continue beyond 31 days.

Legally adopted children (other than newborns) are eligible as soon as they are placed for adoption. Foster children are eligible as soon as they are placed in the foster home.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-sustaining employment because of mental retardation or physical handicap that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support and maintenance; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support

because of mental retardation or physical handicap that began before he or she reached the limiting age.

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

If you have enrolled your Eligible Dependents as a noncustodial parent, Dentegra shall:

1) provide such information to the custodial parent as may be necessary for the child to obtain benefits under this Program;
2) permit the custodial parent (or the health care provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent;
3) make payments on claims submitted as described in the Proofs of Loss section of this EOC directly to the custodial parent, the provider, or the Department of Health and Human Services as directed.

Dentegra will not impose requirements on any state agency that has been assigned the rights of an Enrollee eligible for medical assistance under Medicaid that are different from the requirements that are applicable to an agent or assignee of any other Enrollee in the DeltaCare USA Program.

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

Grace Period

A grace period of 31 days will be granted for the payment of each premium falling due after the initial premium. Notice will must be sent not less than five days prior to the premium due date. The contract will continue in force during the 31 day grace period.

Reinstatement

Acceptance by Dentegra of the proper Premiums after termination of this Contract and without requiring a new application, shall reinstate this Contract as though it had never terminated, unless Dentegra shall, within 20 business days of receipt of such payment, either:

1) refuse the payment so made, or
2) issue to Applicant a new Contract accompanied by written notice stating clearly those respects in which the new Contract differs from this terminated Contract in Benefits, coverage or otherwise.

Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

How to use the DeltaCare USA Program

Dentegra offers a choice of selecting a Dentist from a panel of DeltaCare USA Dentists, or you may choose a Non-DeltaCare USA Dentist. A list of DeltaCare USA Dentists can be obtained by accessing the DeltaCare USA Dentist Directory at deltadentalins.com. Dentists are regularly added to the network. You are responsible for verifying whether the treating Dentist is a DeltaCare USA Dentist. To confirm a Dentist's participation in the DeltaCare USA network, you should contact the Customer Service department at 800-422-4234.

Shortly after enrollment you will receive a membership packet that tells you the effective date of your Program. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call a DeltaCare USA Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

Upon termination of a DeltaCare USA Dentist's agreement, Dentegra shall be liable for Benefits for the completion of treatment for Single Procedures begun prior to the termination of the agreement.

The terminating DeltaCare USA Dentist will complete:
1) a partial or full denture for which final impressions have been taken; and
2) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

If for any reason the DeltaCare USA Dentist is unable to complete treatment, we shall make reasonable and appropriate provisions for the completion of such treatment by another DeltaCare USA Dentist.

Benefits, Limitations and Exclusions

All approved claims for Benefits will be paid by Dentegra less any applicable Copayments as listed in *Schedule A*. You are responsible for the Copayment amount for each covered procedure (see *Schedule A*).
Subject to the limitations and exclusions in *Schedule B*, Dentegra will pay for each of the procedures listed as Benefits on *Schedule A*.

A Dentist may provide services either:
1) personally, or
2) through associated Dentists, or
3) through the other technicians or hygienists who may lawfully perform the services.

In the event Dentegra fails to pay a Dentist, you will not be liable to that Dentist for any sums owed by Dentegra.

DeltaCare USA Dentists
Receiving treatment from a DeltaCare USA Dentist usually provides you the greatest reduction in out-of-pocket expenses. This select group of Dentists will provide dental Benefits at a charge which has been contractually agreed upon between Dentegra and the DeltaCare USA Dentist. Dentegra will pay a DeltaCare USA Dentist either the fee actually charged by the Dentist or the Maximum Fee Allowance, whichever is lower, less the Copayment.

Additional advantages of using a DeltaCare USA Dentist:
The DeltaCare USA Dentist must accept assignment of Benefits. This means Benefits will be paid directly to the Dentist by Dentegra after payment of the Copayment. You do not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement. A Non-DeltaCare USA Dentist may require payment of all charges at the time services are received.

The DeltaCare USA Dentist will complete the dental claim form and submit it to us for reimbursement.

Non-DeltaCare USA Dentists
Procedures listed on Schedule A may also be performed by a Non-Contract Dentist. Dentegra will pay either the fee actually charged by the Dentist or the Maximum Fee Allowance, whichever is lower, less the Copayment. Enrollees who seek treatment from Non-DeltaCare USA Dentists are responsible for the difference, if any, between the amount Dentegra pays and the Non-DeltaCare USA Dentist's usual fee for such treatment.

For covered services provided by a Non-DeltaCare USA Dentist, Dentegra will pay the Enrollee, unless Benefits have been assigned to the Dentist.

Any procedure not listed on *Schedule A* is not a covered Benefit under this Contract.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact a DeltaCare USA Dentist for Emergency Services for covered dental procedures whenever possible. If you are unable to reach a DeltaCare USA Dentist for Emergency Services, you should call Customer Service at 800-422-4234 for assistance in obtaining urgent care.

Notice of Claim

Written notice of claim must be given to Dentegra within 20 days after the occurrence of any loss covered by this Contract, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Enrollee to: Claims Department, P.O. Box 1810, Alpharetta, GA 30023, or to any authorized Dentegra agent, with information sufficient to identify the Enrollee, shall be deemed notice to Dentegra.

Claim Forms

Upon receipt of notice of claim, Dentegra will furnish to the claimant such forms as are usually furnished for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Contract as to proof of loss upon submitting, within the time fixed in section 4.06 for filling proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Claims must be sent within 180 days of the end of treatment. Valid claims received after the 180-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. Except in the absence of legal capacity, all claims must be received no later than one year from the time submittal of the claim is otherwise required.

The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Time of Payment of Claims

Dentegra shall, within 30 calendar days after receipt of a claim, either:

1) make payment of the claim;
2) send notice of denial of the claim; or
3) send notice that information provided on the claim form is inadequate or incomplete.

All claims will be paid or denied within 30 days of receipt of complete information.

Legal Actions

No action at law or in equity shall be brought to recover on the Contract prior to 60 days after proof of loss has been filed in accordance with the requirements of the Contract. No such action shall be brought at all unless brought within two years from the expiration of the time within which proof of loss is required by the Contract.

Entire Contract; Changes

The Contract, the Contract application, and any attached schedules, appendices, endorsements and riders, constitute the entire

agreement between Dentegra and Client. No agent has authority to amend the Contract or waive any of its provisions. No amendment to the Contract shall be valid unless approved by an executive officer of Dentegra and evidenced by endorsements.

Time Limit on Certain Defenses

After two years from the date of issue or reinstatement of the contract, no misstatements made by the Client in the application for this contract shall be used to void the contract or deny a claim for loss incurred commencing after the expiration of the two-year period.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Dentegra, and Dentegra may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Dentegra shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under the Contract. Dentegra shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Dentegra chooses, the amount of any Benefits paid by Dentegra which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Dentegra relies upon the professional judgment of the treating Dentists to determine the appropriate treatment required for a

patient. Dentegra will make coverage decisions by reviewing claims to determine whether the rendered services are covered under the terms of the Contract.

Dentegra or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding:

1) eligibility,
2) the denial of dental services or claims,
3) the policies, procedures or operations of Dentegra or the Administrator, or
4) the quality of dental services performed by a DeltaCare USA Dentist,

you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

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

Written communication must include:

1) the name of the patient,
2) the name, address, telephone number and identification number of the Primary Enrollee,
3) the name of the Client, and
4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Dentegra within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual.

Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a clinical judgment in applying the terms of the Contract, we shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the

review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary, in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of Single Procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this

Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Dentist's facility;
2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during a 31-day grace period and may be reinstated during the term of this Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under the Contract.
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:

1) you and/or your dependents who are enrolled in the Dentegra plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:

1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Dentegra within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage

for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Dentegra within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Dentegra terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Dentegra plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Dentegra plan.

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. **Enrollees should discuss all treatment options with their Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE COPAYMENTS
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost

D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the 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	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by a Dentist, the Enrollee pays the specified Copayment. Enrollees who seek treatment from Non-DeltaCare USA Dentists are responsible for the difference, if any, between the amount Dentegra pays and the Non-DeltaCare USA Dentist's usual fee for such treatment.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the general Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by 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 seven. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Orthodontist's usual fee for the treatment plan. A DeltaCare USA Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the DeltaCare USA Orthodontist as arranged. A Non-DeltaCare USA Orthodontist will make payment arrangements directly with the Enrollee.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Dentegra is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

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

11. Prescription drugs.
12. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
13. Lost, stolen or broken orthodontic appliances.
14. Changes in orthodontic treatment necessitated by accident of any kind.
15. Myofunctional and parafunctional appliances and/or therapies.
16. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
17. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
18. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
19. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Combined Evidence of Coverage and Disclosure Form

NV13B

Provided by:
Alpha Dental of Nevada, Inc.
5920 S. Rainbow Blvd. Suite 10
Las Vegas, NV 89118

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

deltadentalins.com

EVIDENCE OF COVERAGE

DISCLOSURE FORM

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage and Disclosure Form ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Alpha Dental of Nevada, Inc. ("ALPHA") and administered by Delta Dental Insurance Company ("Delta Dental"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by ALPHA.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

This EOC may not be assigned and the Benefits may only be assigned to a Dentist who is treating the Enrollee.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234. These calls will be answered by ALPHA's Administrator, Delta Dental.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental"), operating as an Administrator in the state of Nevada. Administrative functions described in the Contract and in this booklet may be performed by Delta Dental, as designated by Alpha. The mailing address for Delta Dental is P.O. Box 1803, Alpharetta, GA 30023. Delta Dental will answer calls directed to 800-422-4234.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term or a period as otherwise requested by the Client and agreed to by Alpha.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

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

Service Area means the following counties: Clark and Washoe.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be preauthorized by Alpha.

We, Us or Our means Alpha or the Administrator as appropriate.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);
2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children beyond the limiting age. Such dependents must be Full-Time Students and wholly dependent on you for support.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth without premium for a period of 31 days. Legally adopted children (other than newborns) are eligible from and after the moment the child is placed in the physical custody of the Eligible Employee for adoption without premium for a period of 31 days. Notice of birth or adoption and payment of the appropriate premium must be received within 31 days after the date of birth or adoption for coverage to continue beyond 31 days.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

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

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire

to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED BY ALPHA, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Alpha terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and preauthorized by Alpha. Alpha shall respond to a Contract Dentist within 20 days of receipt of a request for referral. All preauthorized Specialist Services will be paid by Alpha less any applicable Copayments.

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

Claims for Reimbursement

Claims for covered Emergency Services or preauthorized Specialist Services must be submitted to Alpha within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. Except for the provisions in *Emergency Services*, if you have not received Preauthorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Alpha, and Alpha may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Alpha shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits

provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Alpha shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Alpha chooses, the amount of any Benefits paid by Alpha which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Alpha shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Alpha, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

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

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Alpha within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Alpha shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within five business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

As described above, an Enrollee may request a review of any decision made by Alpha. Enrollees should first contact the Alpha Customer Service department at the number listed above for assistance with a request for review. Alpha makes every effort to provide satisfactory resolution. In the event your complaint remains unresolved, you may contact the Division of Insurance and pursue the following procedure:

In accordance with Nevada law, the Division of Insurance has established procedure to assist Enrollees in making any additional inquiry or complaint concerning coverage under this Contract. The Enrollee may contact the Division of Insurance by telephone as follows:

Name of Division: The Department of Business and Industry, Division of Insurance

Telephone Numbers:

If the Enrollee has local access to the Carson City Office of the Division, he or she may call 702-687-4270.

If the Enrollee has local access to the Las Vegas Office of the Division, he or she may call 702-486-4009.

If the Enrollee does not have local access to either of those Offices, he or she may call 888-872-3234.

Hours of Operation: Mondays through Fridays from 8 a.m. until 5 p.m., Pacific Standard Time (PST).

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Enrollee Complaint Procedure*, or the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be cancelled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) Upon 15 days written notice if:
   a) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under the Contract;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the premiums are not paid by or on behalf of the Enrollee on the date due; or

c) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
d) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Alpha must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Alpha will notify the Enrollee in writing, at least 30 days in advance, that Alpha considers the dentist-patient relationship to be unsatisfactory. Alpha will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Alpha plan on the day before the Qualifying Event; or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:

1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Alpha within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage

for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's continued coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Alpha within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Alpha terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Alpha plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Alpha plan.

Incontestability

In the absence of fraud or intentional misrepresentation made by you in the enrollment application, all statements made in that application are representations and not warranties. The statements are considered to be truthful and are made to the best of your knowledge and belief. A statement may not be used to void, cancel or non-renew your coverage or reduce Benefits unless (i) it is in a written enrollment application signed by you, and (ii) a signed copy of the enrollment application is or has been furnished to you or your personal representative.

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999	II. PREVENTIVE	
D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

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

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide specialized services, and are referred by the assigned Contract Dentist, must be preauthorized by Alpha. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Alpha, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Alpha is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

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

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

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

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

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

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

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

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

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

- qualified interpreters
- information written in other languages

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Toll Free
800-422-4234

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

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Combined Evidence of Coverage and Disclosure Form

PA13B

Provided by:
Delta Dental of Pennsylvania
One Delta Drive
Mechanicsburg, PA 17055
800-932-0783

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

deltadentalins.com

EVIDENCE OF COVERAGE

DISCLOSURE FORM

DeltaCare® USA Dental Health Care Program

This booklet is a Combined Evidence of Coverage and Disclosure Form ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Delta Dental of Pennsylvania ("Delta Dental"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Delta Dental.

This EOC describes the provisions of the Contract between your employer and Delta Dental. This EOC provides coverage for dental services and Benefits through a preferred provider organization (PPO) arrangement in accordance with the terms and conditions specified in the Contract.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company or other entity designated by Delta Dental, operating as an Administrator in the Commonwealth of Pennsylvania. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

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

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

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

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Delta Dental.

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

We, Us or Our means Delta Dental or the Administrator as appropriate.

Eligibility for Benefits

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

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:
1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include Primary Enrollee's Spouse and unmarried dependent children from birth to age 19, or to age 23 if enrolled as full-time students in an accredited school, college or university. Eligible full-time students include members of the Pennsylvania National Guard or any reserve component of the armed forces of the United States who are called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days; or members of the Pennsylvania National Guard ordered to active state duty, including duty under 35 Pa.C.S. Ch. 76 (relating to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

Eligibility shall be extended for a period equal to the duration of the eligible member's service on active duty or active state duty or until the eligible member is no longer a Full-Time Student. Coverage as a dependent shall not terminate because of the age of the dependent when the Enrollee's educational program was interrupted because of military duty. Proof of continuing eligibility must be furnished as required by Delta Dental.

Full-Time Students who are covered under this program, and are unable to attend school because of an injury or illness, are eligible to continue coverage for one year following the last day of attendance in school. The need for this medical leave of absence must be certified by a medical practitioner licensed to practice in Pennsylvania. In order to continue coverage, the Enrollee must submit this documentation to Delta Dental.

Children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as recognized by the Contractholder. A newborn child is automatically covered for 31 days after birth. For coverage to continue beyond 31 days, notification of birth and payment of Premium will be required. Children/students must be dependent upon the Primary Enrollee for support and maintenance. 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.

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's disability is provided within 31 days of request. Such requests will not be made more than once a calendar year following a two year period after this dependent reaches the limiting age. Enrollment will continue as long as the dependent relies on the Eligible Employee for support because of a physically or mentally disabling injury, illness or condition that began before he/she reached the limiting age.

The dependent child is not required to reside with a parent or legal guardian who is an Enrollee.

Dependents on active military duty are not eligible, except as noted above. No Eligible Dependent may be enrolled under more than one Eligible Employee. Medicare eligibility shall not affect eligibility of an Eligible Employee or Eligible Dependent.

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Program - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department

at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY US, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Delta Dental terminates, that Contract Dentist will complete (1) a partial or full denture for which final impressions have been taken, and (2) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the *Limitations and Exclusions of Benefits*. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after

normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. If you require Emergency Services and are more than 35 miles from the facility of your Contract Dentist, or you are unable to reach your Contract Dentist, Delta Dental shall reimburse you for the cost of such Emergency Services less any applicable Copayment.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by us. All authorized Specialist Services will be paid by us less any applicable Copayments.

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

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. Late claims must be submitted as soon as possible. All claims must be received within one year of the treatment date except in the absence of legal capacity of the claimant. The address for claims submission is Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for the provisions in *Emergency Services*, if you have not received Authorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

Notice of Claim

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

Claim Forms

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

Proofs of Loss

Claims for covered Emergency Dental Services or authorized Specialist Services should be sent to us within 90 days of the end of treatment. Valid claims will be reviewed after 90 days if you can show that it was not reasonably possible to submit the claim within that time. Late claims must be submitted as soon as possible. All claims must be received within one year of the treatment date except in the absence of legal capacity of the claimant.

Time of Payment of Claims

Indemnities payable under this EOC for any loss will be paid immediately upon receipt of due written proof of such loss.

Payment of Claims

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

of Delta Dental, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

Physical Examinations and Autopsy

Delta Dental at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

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 and/or this EOC, 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.

Change of Beneficiary

Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this EOC or to any change of beneficiary or beneficiaries, or to any other charges in this EOC. This does not apply to dental.

Misstatement of Age

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

Conformity with State Statutes

Any provision of the Contract and/or this EOC which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date, is hereby amended to conform to the minimum requirements of such statutes.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental

benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Delta Dental and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under the Contract. Delta Dental shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefits paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

The Administrator will address all Enrollee inquiries, complaints and grievances promptly and professionally. Written records will be maintained classifying such Enrollee contacts by type (i.e. inquiry, complaint or grievance) in a written log. The Administrator will routinely advise Enrollees of their rights under the complaint/ grievance system over the telephone and on all claims and other correspondence which refer to benefits which have been denied.

The Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the Administrator, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

Quality Management Department
P.O. Box 1860
Alpharetta, Georgia 30023

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Delta Dental within at least 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

A systematic progression of appeals will be in place. If the initial decision is appealed and informal resolution has not been possible, it will be addressed by the 1st Level Grievance Committee. If the 1st Level Grievance Committee's decision is appealed, that appeal will be addressed by the 2nd Level Grievance Committee. If the 2nd Level Grievance Committee's decision is appealed, that appeal will be addressed by the Pennsylvania Department of Health. At each step, if the decision is not in your favor, you will be advised (1) of the right to appeal the decision and (2) of how to use the appeal process.

1st Level Grievance Review Committee
Appeals will first be addressed by the 1st Level Grievance Review Committee. The committee is made up of one or more Delta Dental employees. The committee will not include any person whose decision is being appealed or who made the initial determination denying claim or handling a complaint. This first level review may be in the form of a telephone conference, staff meeting or polling of experts by telephone.

You have the right to submit written material and to have an uninvolved staff person assist, but you do not have the right to attend or to have representation in attendance at this stage. The Administrator will advise you of your rights.

The review will be conducted within 30 days of receipt of the appeal. The decision of the 1st Level Grievance Review Committee will be made known to you in writing at the earliest possible time following the review but not more than five working days after the date of the review.

Written decision will contain:

1) Description of the committee's understanding of your grievance as presented to the grievance committee, e.g. dollar amount of the disputed issue, medical facts in dispute, etc.;
2) Committee's decision in clear terms and the contract basis or medical rationale in sufficient detail for you to respond further to the Administrator's position, e.g. did not contact primary care physician, non-emergency service as identified in dental records, or not covered by group contract;
3) Evidence or documentation used as the basis for the decision should be referenced in the letter, e.g. specific provisions, Group contract, dental records, etc.; and
4) Statement indicating:
    a) decision is binding unless you appeal to the second level;
    b) a description of the process on exactly how to appeal to the 2nd Level Grievance Review Committee; and
    c) the written procedures governing appeal including the required timeframe of thirty-five (35) days from the date of the letter for appeal.

2nd Level Grievance Review Committee

Delta Dental's 2nd Level Grievance Committee will be made up of three (3) members. In agreement with the Pennsylvania HMO Act and the Department of Health Regulations, the members will be selected by the Board of Directors and one-third of the members shall be actual Delta Dental Enrollees. A Delta Dental Enrollee will be selected when needed to serve on a Grievance Review Committee. The subscriber member will be selected from among the Delta Dental employer and union groups' benefits administrators who are also Delta Dental Enrollees.

This committee may not include any person previously involved in the grievance. Committee members must have the ability to be fair and impartial. A continuity of the Grievance Committee Membership

is necessary so as to facilitate a knowledgeable and consistent approach to grievance resolution. It is imperative that the committee carefully consider and make particular findings of fact on all key factual disputes.

Provisions Regarding Enrollee Rights

1) You always have a right to attend the 2nd level hearing and to present your case and have the right to be assisted/ represented by a person of your choice. The hearing will be held in Pennsylvania or in another location convenient to you.
2) You may again submit written material in support of your claim. Formal rules of evidence are not appropriate, and you may arrange for a physician or other expert to testify on your behalf.
3) You have the right to question Delta Dental staff concerning the dispute.
4) Your right to a fair and equitable hearing may not be made conditional on your appearance at the hearing. Regardless of your presence or lack of, the hearing must be conducted in the same manner.
5) Delta Dental is responsible for insuring that hearings are held at mutually convenient times. You shall be notified in writing, at least fifteen (15) days in advance, of the date and time of the hearing, which should be held within thirty (30) days of receipt of the appeal. Requests for hearing postponement by you (for just cause) must be considered.
6) You shall receive a description of the Committee's procedures so as to permit you to be prepared for the hearing.
7) You should also be re-advised of your rights to have a non-involved staff person to assist you in preparing for the grievance hearing.

Provisions to Expedite Grievances Where There is Alleged Medical Urgency

Grievances usually deal with claim denials, and the remedy sought is payment of the claim by Delta Dental. In those cases, however, where you believe that serious medical consequences will arise in the near future (7 to 10 days) from Delta Dental's failure to provide needed, medically necessary and covered health services, there is a procedure for expedited review.

In such a case, you should identify the particular need for an expedited review to the Customer Service department. Delta Dental will arrange to have the grievance reviewed by a Delta Dental dental director within forty-eight (48) hours and the dental director will inform you of their decision in writing.

If the dental director's decision is adverse to you, you may appeal the decision immediately to the 2nd Level Grievance Review Committee.

The Bureau of Health Financing & Program Development in the Pennsylvania Department of Health, Room 1026, Health & Welfare Building, P.O. Box 90, Harrisburg, PA 17108-0090 (717-787-5193) is responsible for monitoring Delta Dental compliance with the grievance procedures.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) immediately:
    a) upon loss of eligibility as described in this Evidence of Coverage; or
    b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;

2) upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
   c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Delta Dental must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Delta Dental will notify the Enrollee in writing, at least 30 days in advance, that Delta Dental considers the dentist-patient relationships to be unsatisfactory. Delta Dental will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Delta Dental plan on the day before the Qualifying Event, or

2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:

1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend

coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Delta Dental within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Delta Dental within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Delta Dental plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified

Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Delta Dental plan.

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $100.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes: $200.00

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

D0340 2D cephalometric radiographic image - acquisition, measurement and analysis

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental or the Administrator. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by the Administrator, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

7. A Preexisting Condition is a disease or physical condition caused by illness or injury for which medical advice or treatment has been received within 90 days immediately prior to becoming eligible with the DeltaCare USA Program. Such condition shall be covered after the individual has been covered for more than 12 months under the group contract. Example: Teeth prepared for crowns, root canals in progress.

   If an individual begins comprehensive orthodontic treatment within 90 days immediately prior to becoming eligible under the DeltaCare USA Program, a provision for treatment in progress is available subject to a waiting period of 12 months of continuous coverage under the DeltaCare USA Program unless the individual qualifies for the orthodontic treatment in progress provision.

8. Benefits for a soft tissue management program are limited to those parts which are listed covered services listed on *Schedule A, Description of Benefits and Copayments.*

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Lost, stolen or broken orthodontic appliances.
14. Changes in orthodontic treatment necessitated by accident of any kind.
15. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures D9944, D9945, D9946 (occlusal guard).
16. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
17. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
18. Any part of a preventive or soft tissue management program, which is not a listed covered service on *Schedule A, Description of Benefits and Copayments*.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. We do not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

Coverage for medically necessary health services are available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. We will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. We will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

DeltaCare USA
PO Box 1803 Alpharetta, GA 30023-1803
1-800-422-4234
deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint

Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

We provide free aids and services to people with disabilities to communicate effectively with us, such as:

- qualified sign language interpreters
- written information in other formats (large print, audio, accessible electronic formats, other formats)

We also provide free language services to people whose primary language is not English, such as:

- qualified interpreters
- information written in other languages

If you need these services, contact our Customer Service department.

Protect your oral health. Prevention is the key to avoiding tooth and gum problems. Brush and floss regularly, and visit the dentist for cleanings and exams. To learn more about prevention and avoiding dental problems, visit **mysmileway.com**. You'll find oral health articles, videos and other tools and tips for caring for your teeth. Don't forget to sign up for *Grin!*, our free dental health e-magazine.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call 1-800-422-4234 (TTY: 711).

¿Puede leer este documento? Si no, podemos encontrar a alguien que lo ayude a leerlo. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 1-800-422-4234 (servicio de retransmisión TTY deben llamar al 711). (Spanish)

您能自行閱讀本文件嗎？如果不能，我們可請人幫助您閱讀。您還可以請人以您的語言撰寫本文件。如需免費幫助，請致電 1-800-422-4234 (TTY: 711)。(Chinese)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 1-800-422-4234 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-800-422-4234 (TTY: 711)번으로 연락하십시오. (Korean)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-800-422-4234 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-800-422-4234 (телетайп: 711). (Russian)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نوفر لك من يساعدك في قراءتها. ربما يمكنك أيضًا الحصول على هذا المستند مكتوبًا بلغتك للمساعدة المجانية اتصل بـ 1-800-422-4234 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-800-422-4234 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n'est pas le cas, nous pouvons faire en sorte que quelqu'un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l'assistance gratuitement, veuillez appeler le 1-800-422-4234 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-800-422-4234 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-800-422-4234 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-800-422-4234 (TTY: 711). (Italian)

この文書をお読みになれますか?お読みになれない場合には音読ボランティアを手配させていただきます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、1-800-422-4234 (TTY: 711) までお問い合わせください。(Japanese)

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 1-800-422-4234 (Schreibtelefon: 711). (German)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخواهیم تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 1-800-422-4234 (TTY: 711). (Persian Farsi)

क्या आप इस दस्तावेज़ को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी सहायता करने हेतु किसी की व्यवस्था कर सकते हैं। आप इस दस्तावेज़ को अपनी भाषा में लिखा हुआ भी प्राप्त कर सकते हैं। निशुल्क सहायता के लिए, कृपया यहाँ कॉल करें 1-800-422-4234 (TTY: 711)। (Hindi)

คุณสามารถอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย รับความชวยเหลือฟรีได้โดยโทรไปที่ 1-800-422-4234 (TTY: 711) (Thai)

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ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-800-422-4234 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 1-800-422-4234 (TTY՝ 711): (Armenian)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-800-422-4234 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-800-422-4234 (TTY: 711)។ (Cambodian)

צי קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט,עמעצער דאָ קען איר העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אַז איר קענט באַקומען דעם דאָזיקן דאָקומענט אין אײַער שפּראַך. פֿאַר אומזיסטע הילף קענט איר אַנקלינגען אַט די דאָזיקע נומער: 1-800-422-4234 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'į' yídóołtahígíí nihee hóló. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaagoałdó' nich'į' ádoolnį́łgo bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojį' béésh holdíílnih 1-800-422-4234 (TTY: 711) (Navajo)

If you have any questions or need additional information, call or write:

Toll Free
800-422-4234

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Evidence of Coverage

SC13B

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

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Dentegra Insurance Company ("Dentegra"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Dentegra.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental") or other entity designated by Dentegra, operating as an Administrator in South Carolina. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Dentegra. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Authorization means the process by which Dentegra determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

Dentist means a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

Eligible Employee means any employee or group member who is eligible for Benefits as described in this booklet.

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

Enrollee means an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Dentegra.

We, Us or Our means Dentegra or the Administrator as appropriate.

Eligibility for Benefits

Eligible Employees and Eligible Dependents receive Benefits as soon as they are enrolled in the Program. Subject to cancellation as provided under this Program, enrollment of Eligible Employees and Eligible Dependents is for a minimum period of one year.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:

1) spouse (unless legally separated or divorced);

2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children beyond the limiting age. Such dependents must be Full-Time Students and wholly dependent on you for support.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Children can also include children in your custody pursuant to court order. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days.

Newborn adopted children include a child with respect to whom: adoption proceedings have been instituted by the Enrollee within 31 days after birth and the Enrollee has temporary custody; or adoption proceedings have been completed and a decree of adoption entered within one year from the beginning of proceedings - unless extended by order of the court.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

Dependents in active military service are not eligible. No Eligible Dependent may be enrolled under more than one Eligible Employee. Medicare eligibility shall not affect the eligibility of an Eligible Employee or an Eligible Dependent.

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire

to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY US, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Dentegra terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by us. All authorized Specialist Services will be paid by us less any applicable Copayments.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments*, and

the limitations and exclusions to determine which procedures are covered under this Program.

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be submitted to Dentegra within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time and that the claim was submitted as soon as reasonably possible. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

If requested Dentegra will furnish you with forms for filing proof of loss. If such forms are not sent to you within 15 days after Dentegra receives notice of your claim you will be deemed to have timely submitted written proof covering the occurrence, character and extent of the loss for which your claim was made. All reimbursements will be paid not more than 60 days after receipt of proof of loss. All reimbursements are either payable to the Enrollee, or at Dentegra's option, directly to the provider.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for the provisions in *Emergency Services*, if you have not received Authorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total

Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Dentegra, and Dentegra may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Dentegra shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under the Contract. Dentegra shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Dentegra chooses, the amount of any Benefits paid by Dentegra which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Dentegra or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Dentegra or the Administrator, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

Quality Management Department
P.O. Box 1860
Alpharetta, Georgia 30023

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Dentegra within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide

you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, we shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary, in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such

person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee within the 31-day Premium grace period. The Enrollee may continue to receive Benefits during the 31-day Premium grace period and may be reinstated during the term of this Contract upon payment of any unpaid Premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
   c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Dentegra must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Dentegra will notify the Enrollee in writing, at least 30 days in advance, that Dentegra considers the dentist-patient relationships to be unsatisfactory. Dentegra will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:

1) you and/or your dependents who are enrolled in the Dentegra plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:

1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Dentegra within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Dentegra within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Dentegra terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Dentegra plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Dentegra plan.

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $100.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5 or more years old.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5 or more years old.

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5 or more years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	$70.00
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) .	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes: $200.00

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

D0340 2D cephalometric radiographic image - acquisition, measurement and analysis

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Dentegra. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Dentegra, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Dentegra is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975, (External bleaching for home application, per arch) or for conditions that are a result of hereditary or developmental defects, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel. This exclusion does not apply to teeth capping, prosthodontics, and orthodontics necessary for the treatment of congenital cleft lip or cleft palate.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services, except as noted in Exclusion Number 3.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. We do not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

Coverage for medically necessary health services are available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. We will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. We will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

DeltaCare USA
PO Box 1803 Alpharetta, GA 30023-1803
1-800-422-4234
deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint

Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

We provide free aids and services to people with disabilities to communicate effectively with us, such as:

- qualified sign language interpreters
- written information in other formats (large print, audio, accessible electronic formats, other formats)

We also provide free language services to people whose primary language is not English, such as:

- qualified interpreters
- information written in other languages

If you need these services, contact our Customer Service department.

Protect your oral health. Prevention is the key to avoiding tooth and gum problems. Brush and floss regularly, and visit the dentist for cleanings and exams. To learn more about prevention and avoiding dental problems, visit **mysmileway.com**. You'll find oral health articles, videos and other tools and tips for caring for your teeth. Don't forget to sign up for *Grin!*, our free dental health e-magazine.

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¿Puede leer este documento? Si no, podemos encontrar a alguien que lo ayude a leerlo. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 1-800-422-4234 (servicio de retransmisión TTY deben llamar al 711). (Spanish)

您能自行閱讀本文件嗎？如果不能，我們可請人幫助您閱讀。您還可以請人以您的語言撰寫本文件。如需免費幫助，請致電 1-800-422-4234 (TTY: 711)。(Chinese)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 1-800-422-4234 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-800-422-4234 (TTY: 711)번으로 연락하십시오. (Korean)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-800-422-4234 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-800-422-4234 (телетайп: 711). (Russian)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نوفر لك من يساعدك في قراءتها. ربما يمكنك أيضًا الحصول على هذا المستند مكتوبًا بلغتك للمساعدة المجانية اتصل بـ 1-800-422-4234 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-800-422-4234 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n'est pas le cas, nous pouvons faire en sorte que quelqu'un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l'assistance gratuitement, veuillez appeler le 1-800-422-4234 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-800-422-4234 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-800-422-4234 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-800-422-4234 (TTY: 711). (Italian)

この文書をお読みになれますか?お読みになれない場合には音読ボランティアを手配させていただきます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、1-800-422-4234 (TTY: 711) までお問い合わせください。(Japanese)

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 1-800-422-4234 (Schreibtelefon: 711). (German)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخواهیم تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 1-800-422-4234 (TTY: 711). (Persian Farsi)

क्या आप इस दस्तावेज़ को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी सहायता करने हेतु किसी की व्यवस्था कर सकते हैं। आप इस दस्तावेज़ को अपनी भाषा में लिखा हुआ भी प्राप्त कर सकते हैं। निशुल्क सहायता के लिए, कृपया यहाँ कॉल करें 1-800-422-4234 (TTY: 711)। (Hindi)

คุณสามารถอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย รับความชวยเหลือฟรีได้โดยโทรไปที่ 1-800-422-4234 (TTY: 711) (Thai)

LAP Tagline_CA+National_Doc_10pt_5.5x8.5_032018

ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-800-422-4234 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 1-800-422-4234 (TTY՝ 711): (Armenian)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-800-422-4234 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-800-422-4234 (TTY: 711)។ (Cambodian)

צי קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט,עמעצער דאָ קען איר העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אַז איר קענט באַקומען דעם דאָזיקן דאָקומענט אין אײַער שפּראַך. פֿאַר אומזיסטע הילף קענט איר אַנקלינגען אַט די דאָזיקע נומער: 1-800-422-4234 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'į' yídóołtahígíí nihee hóló. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaagoałdó' nich'į' ádoolnį́łgo bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojį' béésh holdíílnih 1-800-422-4234 (TTY: 711) (Navajo)

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

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Evidence of Coverage

TN13B

Provided by:
Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009
800-422-4234

Administered by:
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023
800-422-4234

deltadentalins.com

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Delta Dental Insurance Company ("Delta Dental"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Delta Dental.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental"), or other entity designated by Delta Dental, operating as an Administrator in the state of Tennessee. Administrative functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

Dentist means a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

Eligible Employee means any employee or group member who is eligible for Benefits as described in this booklet.

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or

immediately required to avoid placing the Enrollee's health in serious jeopardy.

Enrollee means an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Open Enrollment Period / Annual Enrollment and Transfer Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Preauthorization means the process by which Delta Dental determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be preauthorized by Delta Dental.

We, Us or Our means Delta Dental or the Administrator as appropriate.

Eligibility for Benefits

Eligible Employees and Eligible Dependents receive Benefits as soon as they are enrolled in the Program. Subject to cancellation as provided under this Program, enrollment of Eligible Employees and Eligible Dependents is for a minimum period of one year.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:

1) spouse (unless legally separated or divorced);
2) unmarried children from birth up to the limiting age as defined by the Client; and

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Legally adopted children (other than newborns) are eligible during and after the period of probation.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

Dependents in active military service are not eligible. No Eligible Dependent may be enrolled under more than one Eligible Employee. Medicare eligibility shall not affect the eligibility of an Eligible Employee or an Eligible Dependent.

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three

Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED BY THE ADMINISTRATOR, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Delta Dental terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

If a Copayment amount is considered delinquent by a Contract Dentist, you will not be eligible to receive further benefits or transfer to another Contract Dentist. Once payment has been made, all eligibility will be restored.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and preauthorized by the Administrator. All preauthorized Specialist Services will be paid by us less any applicable Copayments.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments*, and the limitations and exclusions to determine which procedures are covered under this Program.

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year and 90 days of the treatment date, except in the absence of legal capacity. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for the provisions in *Emergency Services*, if you have not received Preauthorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Delta Dental, and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement

paid shall be deemed to be Benefits under this Contract. Delta Dental shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefits paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Delta Dental shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

Quality Management Department
P.O. Box 1860
Alpharetta, Georgia 30023

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Delta Dental within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary, in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Enrollee Complaint Procedure*, or the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be cancelled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
   c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Delta Dental must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Delta Dental will notify the Enrollee in writing, at least 30 days in advance, that Delta Dental considers the dentist-patient relationships to be unsatisfactory. Delta Dental will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Delta Dental plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:
1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination

that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Delta Dental within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her

employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Delta Dental within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Delta Dental plan had such plan with

the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Delta Dental plan.

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $100.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes: $200.00

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

D0340 2D cephalometric radiographic image - acquisition, measurement and analysis

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.
21. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
22. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. We do not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

Coverage for medically necessary health services are available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. We will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. We will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

DeltaCare USA
PO Box 1803 Alpharetta, GA 30023-1803
1-800-422-4234
deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint

Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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- qualified sign language interpreters
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We also provide free language services to people whose primary language is not English, such as:

- qualified interpreters
- information written in other languages

If you need these services, contact our Customer Service department.

Protect your oral health. Prevention is the key to avoiding tooth and gum problems. Brush and floss regularly, and visit the dentist for cleanings and exams. To learn more about prevention and avoiding dental problems, visit **mysmileway.com**. You'll find oral health articles, videos and other tools and tips for caring for your teeth. Don't forget to sign up for *Grin!*, our free dental health e-magazine.

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ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-800-422-4234 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 1-800-422-4234 (TTY՝ 711): (Armenian)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-800-422-4234 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-800-422-4234 (TTY: 711)។ (Cambodian)

צי קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט,עמעצער דאָ קען איר העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אַז איר קענט באַקומען דעם דאָזיקן דאָקומענט אין אײַער שפּראַך. פֿאַר אומזיסטע הילף קענט איר אַנקלינגען אַט די דאָזיקע נומער: 1-800-422-4234 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'į' yídóołtahígíí nihee hóló. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaagoałdó' nich'į' ádoolnį́łgo bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojį' béésh holdíílnih 1-800-422-4234 (TTY: 711) (Navajo)

If you have any questions or need additional information, call or write:

Toll Free
800-422-4234

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Combined Evidence of Coverage and Disclosure Form

TX13B

Provided by:
Alpha Dental Programs, Inc.
1701 Shoal Creek, Suite 240
Highland Village, TX 75077

Administered by:
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023
800-422-4234

deltadentalins.com

EVIDENCE OF COVERAGE

DISCLOSURE FORM

This booklet is a Combined Evidence of Coverage and Disclosure Form ("EOC") for your Dental HMO Program ("Program") provided by:

Alpha Dental Programs, Inc. ("ALPHA") dba DeltaCare USA
A Single Service Health Maintenance Organization ("HMO")
1701 Shoal Creek, Suite 240
Highland Village, TX 75077
800-422-4234

The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by ALPHA.

Administrative functions described throughout this booklet may be performed by Delta Dental Insurance Company ("Delta Dental"), a Third Party Administrator, as designated by ALPHA.

This EOC describes the provisions of the Contract between your Group and ALPHA. THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about benefits is 800-422-4234. These calls will be answered by ALPHA's Administrator, Delta Dental.

ALPHA DENTAL PROGRAMS, INC.
ADDENDUM TO CERTIFICATE
TEXAS IMPORTANT NOTICES

Have a complaint or need help?
If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Alpha Dental Programs
To get information or file a complaint with your insurance company or HMO:

Call: Quality Management
1-800-422-4234
Toll Free: 1-800-422-4234
Online: deltadentalins.com
Mail: P.O. Box 1803
Alpharetta, GA 30023

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question:
1-800-252-3439

File a complaint:
www.tdi.texas.gov

Email:
ConsumerProtection@tdi.texas.gov

Mail:
MC 111-1A,
P.O. Box 149091
Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?
Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Alpha Dental Programs
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Quality Management
1-800-422-4234
Teléfono gratuito: 1-800-422-4234
En línea: deltadentalins.com
Direccion postal: P.O. Box 1803
Alpharetta, GA 30023

El Departmento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al:
1-800-252-3439

Presente una queja en:
www.tdi.texas.gov

Correo electrónico:
ConsumerProtection@tdi.texas.gov

Dirección postal:
MC 111-1 A,
P.O. Box 149091
Austin, TX 78714-9091

Notice of Rights Under HMO Plan

- A health maintenance organization (HMO) plan provides no benefits for services You receive from Out-of-Network Dentists, with specific exceptions as described in the Contract and this notice.

- You have the right to an adequate network of in-network Dentists (also known as network Dentists).

- If You believe that Our network is inadequate, You may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.

- If We approve a referral for Out-of-Network services because no in-network Dentist is available, or if You have received Out-of-Network Emergency Dental Services, We must, in most cases, resolve the Out-of-Network Dentist's bill so that You only have to pay any applicable in-network Copayment, Coinsurance, and Deductible amounts.

- You may obtain a current directory of in-network Dentists by visiting Our website at deltadentalins.com or calling Our Customer Service department at 800-422-4234 for assistance in finding available in-network Dentists. If You relied on materially inaccurate directory information, You may be entitled to have a claim by an Out-of-Network Dentist paid as if it were from a network Dentist, if You present a copy of the inaccurate directory information to Us, dated not more than 30 days before You received the service.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental"), licensed as a Third Party Administrator in the State of Texas. Administrative functions described in the Contract and in this booklet may be performed by Delta Dental, as designated by Alpha. The mailing address for Delta Dental is P.O. Box 1803, Alpharetta, GA 30023. Delta Dental will answer calls directed to 800-422-4234.

Benefits mean those dental services available under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialty Care Dentist means a Dentist who provides Specialized Services, and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Dentist for the Benefits provided under this Program.

Dentist means a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

Eligible Employee means any employee or group member who is eligible for Benefits as described in this booklet.

Emergency Dental Services means procedures administered in a Dentist's facility, emergency dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an

average knowledge of dentistry to believe that immediate care is needed.

Enrollee means an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the commencement of the contract term or a period as otherwise requested by the Client and agreed to by Alpha.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Preauthorization means the process by which Alpha determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Service Area means the State of Texas, except for the following counties:

> Collingsworth, Culberson, Dallam, Edwards, Hansford, Hemphill, Lipscomb, Motley, Ochiltree, Reeves, Roberts, Sherman, Terrell, Val Verde, and Wheeler.

Specialized Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry and which must be preauthorized by us.

We, Us or Our means Alpha or the Administrator, as appropriate.

Eligibility for Benefits

Eligible Employees and Eligible Dependents receive Benefits as soon as they are enrolled in the Program. Subject to cancellation as provided under this Program, enrollment of Eligible Employees and Eligible Dependents is for a minimum period of one year.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);
2) unmarried children from birth up to age 25;

Children include natural children, stepchildren, adopted children, foster children, and grandchildren provided all such children are dependent on you for support. Grandchildren must reside with you to be eligible. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Foster children are eligible from and after the moment the child is placed in your physical custody. Legally adopted children (other than newborns) are eligible from and after the moment you file suit for adoption.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a physical disability or mental incapacity that began before age 25;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

Dependents in active military service are not eligible. No Eligible Dependent may be enrolled under more than one Eligible Employee. Medicare eligibility shall not affect the eligibility of an Eligible Employee or an Eligible Dependent.

You must live or work in Alpha's Service Area. The permanent legal residence of any enrolled dependent must be the same as yours, or you must live or work in the Service Area and the residence of any enrolled dependent must be:
1) in Alpha's Service Area with the person having temporary or permanent conservatorship or guardianship of such dependents, where you have legal responsibility for the health care of such dependents; or
2) in Alpha's Service Area under other circumstances where you are legally responsible for the health care of such dependents; or

3) in Alpha's Service Area with your spouse; or
4) anywhere in the United States for a child whose coverage under the Program is required by a medical support order.

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the Program - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALTY CARE DENTIST PREAUTHORIZED BY US, OR FOR EMERGENCY DENTAL SERVICES (REFER TO SCHEDULE A). SPECIALIZED SERVICES THAT ARE NOT AUTHORIZED BY US MAY NOT BE COVERED. ANY OTHER TREATMENT PROVIDED BY AN OUT-OF-NETWORK DENTIST IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Alpha terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment.

Emergency Dental Services

You should contact your Contract Dentist for Emergency Dental Services for covered dental procedures whenever possible. If you require Emergency Dental Services and are unable to reach your Contract Dentist, you should call Customer Service at 800-422-4234 for assistance in obtaining urgent care; or during non-business hours, you may seek immediate treatment from another Dentist and we will reimburse you for the cost of Emergency Dental Services which exceeds your Copayment(s). Emergency Dental Services are limited to listed procedures and as described in code D9110 "Palliative (emergency) treatment of dental pain." Further treatment must be obtained from the assigned Contract Dentist. (Refer to *Schedule A*).

Specialized Services

Specialized Services for oral surgery, endodontics, periodontics or pediatric dentistry must be referred by the assigned Contract Dentist and preauthorized by us. All preauthorized Specialized Services will be paid by us less any applicable Copayments. (Refer to *Schedule A*).

IF YOU REQUIRE SPECIALIZED SERVICES AND THERE IS NO CONTRACT SPECIALTY CARE DENTIST TO PROVIDE THESE SERVICES WITHIN 35 MILES OF YOUR HOME ADDRESS, YOUR ASSIGNED CONTRACT DENTIST MUST RECEIVE PREAUTHORIZATION FROM US TO REFER YOU TO AN OUT-OF-NETWORK DENTIST TO PROVIDE THE SPECIALZED SERVICES. SPECIALIZED SERVICES PERFORMED BY AN OUT-OF-NETWORK DENTIST THAT ARE NOT PREAUTHORIZED MAY NOT BE COVERED.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments*, and the limitations and exclusions to determine which procedures are covered under this Program.

Claims for Reimbursement

Claims for covered Emergency Dental Services or preauthorized Specialized Services must be submitted to us within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date.

We will acknowledge receipt of Enrollee claims in writing and initiate investigation of claims within 15 days. The Enrollee will be requested to provide additional information, if required.

Claims submitted with all necessary information will be accepted or rejected within 15 business days of receipt. Notice of rejected claims will state the reason for the rejection. In the event additional information is required and a determination cannot be made, you will receive written notification within this 15-day period stating the reason for the delay.

All claims will be accepted or rejected within 45 days of that notice. Accepted claims will be paid not later than the fifth business day following notice of acceptance. If payment is subject to performance of an act by the Enrollee, the claim will be paid not later than the fifth business day after the date the act is performed.

In the event that we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. Except for the provisions in *Emergency Dental Services*, if you have not received Preauthorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services. For further clarification, refer to the provisions for Emergency Dental Services and Specialized Services.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program for Specialized Services or by out-of-network Dentists are coordinated with such other group dental insurance policy or any

group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to us and we may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. We will, in our sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement will be deemed to be Benefits under this Program. We will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as we choose, the amount of any Benefits paid by us which exceeds our obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

A complaint means any dissatisfaction expressed by an Enrollee orally or in writing about any aspect of our operation, including but not limited to dissatisfaction with administration; procedures; denial, reduction or termination of services for reasons **not related to medical necessity**; disenrollment decisions or the quality of dental services performed by a Contract Dentist. You may call the Customer Service department at 800-422-4234 or write to: Quality Management Department, P.O. Box 1860, Alpharetta, GA 30023-1860.

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

A complaint does **not** include a misunderstanding or problem of misinformation which can be promptly resolved by supplying correct information to the Enrollee's satisfaction.

We do not make determinations about the medical necessity of dental services and only determine if services are covered Benefits under the Contract. We will provide notification if any dental

services are not covered Benefits, stating the specific Contract provision(s).

Within five business days after receipt of an oral or written complaint, the quality management coordinator will send a letter acknowledging the date of receipt of the complaint, and a description of our complaint procedures, estimated time frames for resolution of complaints, and a request for any necessary information. If the complaint was received orally, the acknowledgement will include a one-page complaint form with instructions to return for prompt resolution of the complaint. **Processing of a complaint will generally not begin until we receive the information shown above, except as noted below for complaints involving Emergency Dental Services.**

The complainant may call the Customer Service department at 800-422-4234 at any time between 7:00 a.m. and 8:00 p.m., Central Time, to discuss the complaint. Those complaints requiring professional expertise shall be referred to a licensed dental consultant or, if necessary, the dental director for response. Certain complaints may also require a second opinion for a clinical evaluation of the dental services provided. Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Alpha's dental consultant. We will only pay for a second opinion that we have authorized.

We will resolve a complaint involving Emergency Dental Services within 24 hours after our receipt. Complaints that do not involve Emergency Dental Services will be resolved within 30 calendar days after receipt. We will send to the complainant a written report which describes the complaint and our resolution. The report will contain a statement of the specific clinical and/or contractual reasons for the resolution and will advise the complainant of:

1) the specialization of any Dentist or other provider consulted;
2) a description of our appeal procedure; and
3) the time frames for our appeal process and final decision.

In the event a complainant is not satisfied with our resolution of a complaint, he/she will have the right to appeal the decision before a complaint appeal panel. Within five business days after receipt of a request for an appeal, we will send a letter acknowledging the date of receipt of the request and include a statement of the complainant's rights to:

1) appear before an appeal panel in person (or through a representative if a minor or disabled) in the area where the Enrollee received the care or at an agreed upon location; or
2) write to an appeal panel;
3) to present alternative expert testimony;
4) to present oral or written information; and
5) to question those responsible for the prior resolution.

Our appeal panel is composed of Enrollee representatives, Contract Dentist representatives and Alpha representatives in equal numbers. Contract Dentists cannot review a case in which they rendered care or a case they reviewed during our complaint or appeal process. The panel will include a Contract Specialty Care Dentist if the quality of specialty care is at issue. Our employees cannot serve as Enrollee members.

No later than five business days before the scheduled meeting of the appeal panel, unless the complainant agrees otherwise, we shall provide to the complainant or the complainant's designated representative:
1) any documentation to be presented to the panel by us;
2) the specialization of any providers consulted during the investigation of the appeal; and
3) the name and affiliation of each Alpha representative on the panel.

We will send a written resolution of the appeal within 30 calendar days after receipt of an appeal. Investigation and resolution of appeals involving ongoing Emergency Dental Services will be concluded in accordance with the dental immediacy of the case, but no later than 24 hours after receipt of request for appeal. At the request of the Enrollee, we will provide, instead of an appeal panel, a provider who has not previously reviewed the case and who is of the same or similar specialty as ordinarily manages the procedure or treatment under appeal. The provider reviewing the appeal may interview the Enrollee or the Enrollee's designated representative and will make a decision on the appeal. Initial notice of decision of the appeal may be delivered orally, but will be followed by a written notice of the determination within three days.

Notice of our final decision will include a statement of the specific clinical and/or contract provision(s) on which the decision was based, and the toll-free telephone number and address of the Texas Department of Insurance.

Any Enrollee, including an Enrollee who has attempted to resolve a complaint through the complaint process described above, may file a complaint with the Texas Department of Insurance at P.O. Box 149091, Austin, Texas 78714-9091. The Department's toll-free telephone number is 800-252-3439.

The commissioner will investigate a complaint against us to determine our compliance with the insurance laws within 60 days after the Department receives the complaint and all information necessary for the Department to determine compliance. The commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

1) additional information is needed;
2) an on-site review is necessary;
3) we, the provider, or the complainant do not provide all documentation necessary to complete the investigation; or
4) other circumstances beyond the control of the Department occur.

We will not engage in any retaliatory action (including termination or refusal to renew a Contract) against a Client, an Enrollee, or a Dentist (on behalf of an Enrollee) for filing a complaint or appealing a decision.

For group health plans subject to the Employee Retirement Income Security Act of 1974 (ERISA):

Enrollees with complaints involving a denial, modification or termination of a requested benefit or claim must file a request for review with us within 180 days after receipt. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who reviewed the original claim, nor the subordinate of such individual. Upon request and free of charge, we will provide the Enrollee with copies of any pertinent documents that are relevant to the claim and a copy of any internal rule, guideline or protocol relied upon in making the decision. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

The Enrollee may also contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim; to ask questions about the rights under ERISA; or bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee

Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide 60 days notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Enrollee Complaint Procedure*, or the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be cancelled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;

2) Upon 15 days written notice if the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under the Program;

3) Upon 30 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due or within the 30-day premium grace period. However, the Enrollee may continue to receive Benefits during the 30-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium. If coverage is not reinstated, the Enrollee will be responsible for the cost of services rendered during the 30-day grace period; or
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or

c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. We must show that we have, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, we will notify the Enrollee in writing, at least 30 days in advance, that we consider the dentist-patient relationships to be unsatisfactory. We will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes; or

d) the Primary Enrollee or the Dependent Enrollee neither resides, lives or works in Alpha's Service Area. However, coverage for a child who is the subject of a medical support order cannot be cancelled solely because the child does not reside, live or work in Alpha's Service Area;

4) Upon 60 days written notice if the Contract is terminated or not renewed.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

COBRA Continuation Option

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:

1) you and/or your dependents who are enrolled in the Alpha plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:

1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Alpha within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage

for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of Alpha's Service Area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Alpha within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Alpha terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Alpha plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Alpha plan.

Group Continuation Option

An Enrollee whose coverage under the Contract ceases for any reason other than involuntary termination for cause, and who has been continuously covered under the Contract for at least three consecutive months immediately prior to such termination, may request continuation of coverage for himself or herself and any covered Dependent Enrollees, subject to the following requirements:

1) Continuation must be requested in writing, and received by the Client together with the first contribution, within 31 days after the later of (a) the date coverage would otherwise terminate, or (b) the date the Enrollee is given notice of the right to elect continuation.
2) The Enrollee must remit to the Client, monthly in advance, the amount of contribution required for continuation plus 2% of the amount of the group rate for coverage under the Contract.
3) Coverage so continued will terminate on the first of the following dates:
    a. The date coverage has been in force for six months;
    b. The date the Enrollee fails to remit required contributions in a timely manner;
    c. With respect to any person whose coverage is being continued, the date that person becomes covered for similar benefits under any program arranged by any other group; or
    d. The date on which the Contract is terminated in its entirety.

Entire Contract

This EOC, the Group Contract, the Contract Application, and any attached schedules, appendices, endorsements and riders to the Contract, constitute the entire agreement governing the Program. No amendment is valid unless approved by an executive officer of Alpha and attached to this EOC. No agent has authority to amend this EOC or waive any of its provisions.

Incontestability

In the absence of fraud or intentional misrepresentation made by you in the enrollment application, all statements made in that application are representations and not warranties. The statements are considered to be truthful and are made to the best of your knowledge and belief. A statement may not be used to void, cancel or non-renew your coverage or reduce Benefits unless (i) it is in a written enrollment application signed by you, and (ii) a signed copy of the enrollment application is or has been furnished to you or your personal representative.

Conformity with State Law

If this EOC is not in conformity with Texas laws or other applicable laws, it will not be rendered invalid but will be construed and applied as if it were in full compliance with Texas law and other applicable laws.

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under this Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months* [1]	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost

D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months* [1]	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period* [1]	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)* [1]	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period* [1]	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)* [1]	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period* [1]	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00

D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00
D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $100.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00

D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00
D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00

D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00
D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00

D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00
D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00

D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00
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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00

D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00

D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00

D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00
D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00

D7251	Coronectomy - intentional partial tooth removal	$115.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	$70.00
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) .	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes: $200.00

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

D0340 2D cephalometric radiographic image - acquisition, measurement and analysis

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Alpha. The Enrollee pays the Copayment specified for such services.

FOOTNOTES

[1] *Frequency limitations do not apply when services are needed more frequently due to medical necessity as determined by the Contract Dentist.*

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Alpha, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Benefits for dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with this Program are limited as follows:

   Upon request of a newly covered Enrollee, Alpha will provide Benefits for the completion of covered services begun prior to the time his or her coverage became effective. Alpha will not provide coverage for incomplete services that are not otherwise Benefits under the terms and conditions of the Contract. Enrollees may request completion of treatment in progress by calling the Customer Service department at 800 422-4234

during normal business hours, or by sending a written request to Alpha.

Whenever possible, an Enrollee should complete treatment in progress with the Dentist who initiated the service. If such Dentist is an out-of-network Dentist, that Dentist must agree to the same terms and conditions that apply to an in-network Dentist in order for Alpha to provide Benefits. Copayments and other cost sharing components will apply. Benefits may be adjusted so that the total paid by the Enrollee and/or coverage provided by all plans is not more than 100% of total Allowable Expenses (as defined in the Coordination of Benefits section of the Contract).

Should the Enrollee be unable to complete treatment with the Dentist who initiated the service, Alpha will make reasonable and appropriate arrangements for completion of such treatment by a Contract Dentist.

7. Orthodontic treatment in progress is limited to new Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under this Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Alpha is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Dental Services* as described in *Schedule A*.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Lost, stolen or broken orthodontic appliances.
14. Changes in orthodontic treatment necessitated by accident of any kind.
15. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures D9944, D9945, D9946 (occlusal guard).
16. Composite or ceramic brackets, lingual adaption of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
17. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
18. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
19. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Glossary

The following dental terms have the meanings indicated:

Abrasion - The abnormal wearing away of the tooth by chewing, incorrect brushing methods, grinding or similar causes.

Alveoloplasty - A surgical procedure to reshape the jaw bones to achieve normal bone contour in preparation for tooth replacement via denture, partials or bridges.

Amalgam - A metal alloy used in filling teeth.

Apicoectomy - The surgical removal of the root tip.

Appliance - A device used to provide function or therapeutic effect.

Attrition - The normal loss of tooth substance resulting from friction during chewing.

Banding - Application of preformed stainless steel rings that are fitted around the teeth and cemented in place.

Banding dentition - Treatment of a tooth which involves banding (for orthodontic purposes).

Cephalometric x-rays - X-rays used in studying the measurements of the head in relation to specific soft tissue and bony reference points.

Cleft palate - A birth defect resulting in an incomplete closure or formation of the palate.

Debridement - The removal of plaque and tartar, above and below the gumline, which makes the ability to evaluate the gum condition difficult.

Equilibration - Changing the occlusal forms of the teeth by selective grinding, with the interest of balancing occlusal stresses more evenly on the teeth.

Erosion - Chemical or mechanical destruction of tooth substance, the mechanism of which is incompletely known, that leads to the creation of a depression in the tooth surface at the gumline.

Exostosis - An excessive growth of bone.

Expansion appliance - An appliance used to widen a dental arch to increase the room available for permanent teeth and/or to correct the bite.

Frenum - The fibers that attach the cheek, lips or tongue to the tissue lining the mouth.

Frenectomy - Surgical removal or loosening of the frenum.

Functional appliance - An appliance used to achieve minor tooth movement, to strengthen the muscles of the oral cavity or to maintain space created by the loss or delayed eruption of the teeth.

Gingiva - The soft tissue which covers a tooth or the gum surrounding a tooth.

Gingivectomy - The surgical removal of the unsupported gingiva to the level where it is attached.

Gingivoplasty - Surgical contouring of the gingiva to facilitate maintenance of tissue health and integrity.

Headgear - An apparatus encircling the head or neck that provides attachment for an intraoral appliance in use of extraoral anchorage.

Implant - A device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement of a missing tooth.

Lingual - Pertaining to the tongue.

Macrognathia - A definite overgrowth of the mandible and maxilla.

Mandible - The lower jaw.

Mandibular - Pertaining to the lower jaw.

Maxilla - The upper jaw.

Maxillary - Pertaining to the upper jaw.

Micrognathia - An abnormal smallness of the jaws, especially the mandible.

Myofunctional therapy - Training to curb or eliminate abnormal muscle function of the oral cavity.

Occlusal - The chewing surfaces of the posterior teeth.

Occlusion - The contact between the upper and lower teeth when in a closed position.

Orthodontic appliance - Any appliance used to apply forces for tooth movement during orthodontic treatment.

Palate - The roof of the mouth.

Palatal - Pertaining to the roof of the mouth.

Palliative - Action that relieves pain but does not cure the cause of the pain.

Panoramic film - An x-ray that offers a full view of the entire length of the jaws in a single x-ray.

Pediatric or **Pedodontic** - Pertaining to children.

Periapical - The area surrounding or enclosing the root tip of a tooth.

Periodontitis - Gingival changes that occur due to infection and loss of attachment between the tooth and gums. Periodontitis is a long-term progressive disease.

Periradicular - Around the root.

Pontic - The term used for the artificial tooth on a bridge.

Prophylaxis - The removal of plaque, tartar and stains on the crown portion of the teeth, including polishing.

Pulp cap - The covering of an exposed dental nerve with material that protects it from foreign irritants.

Quadrant - One of the four equal sections into which the dental arches can be divided; begins at the middle of the arch and goes to the last tooth on either side.

Rebase - Process of refitting a denture by replacing the acrylic base material.

Resin - Broad term used to indicate an organic substance that is usually tooth colored. Composite resin used in filling teeth, most often in the front of the mouth.

Retainer - An appliance used to maintain the positions of the teeth and jaws gained by orthodontic procedures.

Retrograde filling - A method of sealing the root canal by preparing and filling it from the root tip.

Root planing - A procedure designed to remove bacteria, tartar and diseased root tissue from the root surfaces. Often referred to as "deep cleaning."

Sealant - Application of a resin material to the biting surfaces of the permanent molars to seal the surface crevices to prevent the formation of decay.

Study model - A positive likeness of dental structures (teeth and adjoining tissues) for the purpose of study and treatment planning.

Supernumerary - Any tooth in excess of the 32 normal permanent teeth.

Temporomandibular joint - The joint formed by the connection of the lower jaw to the skull.

Tracing - As it relates to orthodontic treatment, a tracing is a line drawing of pertinent features of a cephalometric x-ray made on a piece of transparent paper placed over an x-ray. The tracing provides measurements of soft tissue and bony reference points that aid in predicting growth patterns and orthodontic diagnosis and treatment planning.

Trigeminal nerve - The main nerve that provides feeling to the muscles and tissues of the face, jaws and teeth.

Vertical dimension - The vertical height of the face with teeth in occlusion.

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Coverage for medically necessary health services are available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. We will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. We will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

DeltaCare USA
PO Box 1803 Alpharetta, GA 30023-1803
1-800-422-4234
deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint

Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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- written information in other formats (large print, audio, accessible electronic formats, other formats)

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- qualified interpreters
- information written in other languages

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Protect your oral health. Prevention is the key to avoiding tooth and gum problems. Brush and floss regularly, and visit the dentist for cleanings and exams. To learn more about prevention and avoiding dental problems, visit **mysmileway.com**. You'll find oral health articles, videos and other tools and tips for caring for your teeth. Don't forget to sign up for *Grin!*, our free dental health e-magazine.

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Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 1-800-422-4234 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-800-422-4234 (TTY: 711)번으로 연락하십시오. (Korean)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-800-422-4234 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-800-422-4234 (телетайп: 711). (Russian)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نوفر لك من يساعدك في قراءتها. ربما يمكنك أيضًا الحصول على هذا المستند مكتوبًا بلغتك للمساعدة المجانية اتصل بـ 1-800-422-4234 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-800-422-4234 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n'est pas le cas, nous pouvons faire en sorte que quelqu'un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l'assistance gratuitement, veuillez appeler le 1-800-422-4234 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-800-422-4234 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-800-422-4234 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-800-422-4234 (TTY: 711). (Italian)

この文書をお読みになれますか?お読みになれない場合には音読ボランティアを手配させていただきます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、1-800-422-4234 (TTY: 711) までお問い合わせください。(Japanese)

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 1-800-422-4234 (Schreibtelefon: 711). (German)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخواهیم تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 1-800-422-4234 (TTY: 711). (Persian Farsi)

क्या आप इस दस्तावेज़ को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी सहायता करने हेतु किसी की व्यवस्था कर सकते हैं। आप इस दस्तावेज़ को अपनी भाषा में लिखा हुआ भी प्राप्त कर सकते हैं। निशुल्क सहायता के लिए, कृपया यहाँ कॉल करें 1-800-422-4234 (TTY: 711)। (Hindi)

คุณสามารถอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย รับความชวยเหลือฟรีได้โดยโทรไปที่ 1-800-422-4234 (TTY: 711) (Thai)

LAP Tagline_CA+National_Doc_10pt_5.5x8.5_032018

ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-800-422-4234 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 1-800-422-4234 (TTY՝ 711): (Armenian)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-800-422-4234 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-800-422-4234 (TTY: 711)។ (Cambodian)

צי קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט,עמעצער דאָ קען איר העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אַז איר קענט באַקומען דעם דאָזיקן דאָקומענט אין אײַער שפּראַך. פֿאַר אומזיסטע הילף קענט איר אַנקלינגען אַט די דאָזיקע נומער: 1-800-422-4234 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'į' yídóołtahígíí nihee hóló. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaagoałdó' nich'į' ádoolnį́łgo bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojį' béésh holdíílnih 1-800-422-4234 (TTY: 711) (Navajo)

If you have any questions or need additional information, call or write:

Toll Free
800-422-4234

Administered by:

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Evidence of Coverage

VA13B

Provided by:
Delta Dental of Virginia
4818 Starkey Road
Roanoke, VA 24018-8542
540-989-8000
800-862-0838
TTY/TDD: 877-287-9039

Administered by:
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023
800-422-4234

deltadentalins.com

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Delta Dental of Virginia ("Delta Dental"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Delta Dental.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

As a Managed Care Health Insurance Plan operating in the Commonwealth of Virginia, Delta Dental is subject to regulation by both the Virginia State Corporation - Bureau of Insurance (pursuant to Title 38.2 of the Code of Virginia) and the Virginia Department of Health (pursuant to Title 32.1 of the Code of Virginia).

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company or other entity designated by Dentegra, operating as an Administrator in the Commonwealth of Virginia. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Dentegra. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, Georgia 30023. The Administrator will answer calls directed to 800-422-4234.

Authorization means the process by which Dentegra determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry and has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics and has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

Dentist means 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 means a person who, together with the Eligible Employee, has affirmed a domestic partnership through an affidavit of domestic partnership filed with the Client.

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

Eligible Employee means any employee or group member who is eligible for Benefits as described in this booklet.

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

Enrollee means an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Full-Time Student means a student who is regularly attending an accredited school on a full-time basis as defined by the appropriate educational institution.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Service Area means Northern Virginia, Tidewater and Richmond metropolitan areas.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Dentegra.

Spouse means a person related to the Primary Enrollee:
- as defined and as may be required to be treated as a Spouse by the laws of the state where this Contract is issued and delivered; and
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides.

We, Us or Our means Dentegra or the Administrator as appropriate.

Eligibility for Benefits

Eligible Employees and Eligible Dependents receive Benefits as soon as they are enrolled in the Program. Subject to cancellation as provided under this Program, enrollment of Eligible Employees and Eligible Dependents is for a minimum period of one year.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:

1) spouse (unless legally separated or divorced);
2) Domestic Partner (until such partnership is terminated by either or both parties);
3) unmarried children from birth up to the limiting age as defined by the Client.

Children include natural children, stepchildren, adopted children, foster children and children of a Domestic Partner provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. If additional premium is required in order to add the dependent newborn child, notice of birth and additional premium must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Legally adopted children (other than newborns) are eligible from and after the date of placement for the purpose of adoption.

An unmarried dependent child may continue eligibility if:

1) he or she is incapable of self sustaining employment because of intellectual disability or physical handicap that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support and maintenance; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after the two year period following the date this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or

physical disability that began before he or she reached the limiting age.

Dependents in active military service are not eligible. No Eligible Dependent may be enrolled under more than one Eligible Employee. Medicare eligibility shall not affect the eligibility of an Eligible Employee or an Eligible Dependent.

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Program - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of

Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY US, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Dentegra terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Should a Contract Dentist's agreement with Dentegra terminate, we will notify all Enrollees who are currently receiving treatment from that Dentist. Unless such termination was for cause and upon request, an Enrollee may continue to receive dental services for an active course of treatment for a period of up to 90 days from the date of a Contract Dentist's termination from the Dentegra provider network.

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by us. All authorized Specialist Services will be paid by us less any applicable Copayments.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments* and limitations and exclusions to determine which procedures are covered under this Program.

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be submitted to Dentegra within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. The address for claims submission is Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for the provisions in *Emergency Services*, if you have not received Authorization for treatment from an out-of-network

Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services.*

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program.

When Benefits are coordinated with another group dental insurance policy or group dental benefits program, the determination of which policy or program is primary shall be governed by the following rules:

1) The policy or program covering the Enrollee as other than a dependent shall be primary over the policy or program covering the Enrollee as a dependent.
2) The policy or program covering a child as a dependent of a parent whose birthday occurs earlier in a calendar year shall be primary over the policy or program covering a child as a dependent of a parent whose birthday occurs later in a calendar year (except for a dependent child whose parents are separated or divorced as described in 3) below). If both parents have the same birthday, the plan that covered either of the parents longer is primary.
3) In the case of a dependent child whose parents are legally separated or divorced:
    a) If the parent with custody has not remarried, the policy or program covering the child as a dependent of the parent with custody shall be primary over the policy or program covering the child as a dependent of the parent without custody.
    b) If the parent with custody has remarried, the policy or program covering the child as a dependent of the parent with custody shall be primary over the policy or program covering the child as a dependent of the step-parent, and the policy or program covering the child as a dependent of the step-parent shall be primary over the policy or program covering the child as a dependent of the parent without custody.

c) If there is a court decree that establishes financial responsibility for dental services which are Benefits under this program, and if the plan with responsibility for payment has actual knowledge of the existence of the court decree, notwithstanding 3) a) and b), the policy or program covering the child as a dependent of the parent with such financial responsibility shall be primary over any other policy or program covering the child.

4) If the primary policy or program cannot be determined by the rules described in 1), 2) or 3), the policy or program which has covered the Enrollee for a longer period of time shall be primary, with the following exception: A policy or program covering the Enrollee as a laid-off or retired employee or the dependent of a laid-off or retired employee shall not be primary under this rule 4) over a policy or program covering the Enrollee as an employee or the dependent of an employee. However, if the provisions of the other policy or program do not include this exception, which results in benefits under neither being primary, then this exception shall not apply.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

An Enrollee shall provide to Dentegra, and Dentegra may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Dentegra shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Dentegra shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Dentegra chooses, the amount of any Benefits paid by Dentegra which exceeds its obligations under these coordination of benefit provisions.

Appeals and Grievances

IMPORTANT INFORMATION REGARDING THIS INSURANCE COVERAGE

In the event you need to contact someone about this insurance for any reason, you should contact us at the following address and telephone number:

Quality Management Department
P.O. Box 1860
Alpharetta, GA 30023
Telephone: 800-422-4234

We recommend that you familiarize yourself with the grievance and appeal procedures described below before taking any other action. If you have been unable to contact or obtain satisfaction from Dentegra, you may contact the Virginia State Corporation Commission's Bureau of insurance at:

Address:
Consumer Service Section
Virginia Bureau of Insurance
P. O. Box 1157
Richmond, VA 23218

Telephone Toll-Free:
800-552-7945 (Virginia only)
877-310-6560 (Nationwide)

Richmond:
804-371-9691

Fax:
804-371-9944

Email:
bureauofinsurance@scc.virginia.gov

Web Page:
http://www.scc.virginia.gov/division/boi

Address:
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401

Richmond, VA 23233-1463

Telephone Toll-Free:
800-995-1819

Richmond:
804-367-2106

Fax:
804-527-4503

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mchip@vdh.virginia.gov

Web Page:
http://www.vdh.virginia.gov

You have the right to appeal a denied claim or adverse benefit determination. Adverse benefit determinations are decisions we make that result in denial, reduction or termination of a Benefit or amount paid. It also means a decision not to provide a Benefit or service. Adverse benefit determinations can result from one or more of the following:

1) The individual is not eligible to participate in the dental plan; or
2) We determine that a Benefit or service is not a covered Benefit because:
   a) it is not included in the list of covered Benefits;
   b) it is specifically excluded;
   c) a Benefit limitation under the dental plan has been reached; or
   d) it is not necessary or customary for the diagnosis or treatment of the condition (Dental Necessity).

We will provide you with written or electronic notification of any denial or adverse benefit determinations. For complaints involving an adverse benefit determination, you must file a request for review (a complaint) with us within 180 days after receipt of the initial adverse determination and within 30 days for any subsequent adverse determinations. You may authorize a representative to act on your behalf in pursuing a claims review or claims appeal. We may require that you identify the authorized representative in writing in advance. For an urgent care claim, you may designate a dental care professional, who is knowledgeable about your dental condition, to act on your behalf. We will deal directly with the authorized representative, rather than you, for matters involving the claim or appeal.

Our written response to an appeal received from you or your authorized representative will be sent to you or your authorized representative according to the following timetable.

1) Urgent Care Health Claim - Claims for conditions that could jeopardize life, health, or ability to regain maximum function, or would subject you to severe pain. Claims where the reasonable layperson standard is used, except that if a physician determines the condition is urgent. We must accept the physician's determination.
   We have 72 hours after receiving the appeal to notify you or your authorized representative of our appeal decision.
2) Improper or Incomplete Claim (Urgent) - A claim that does not include enough information for us to make a determination.
   We have 72 hours after receiving the appeal to notify you or your authorized representative of our appeal decision.
3) Pre-Service Health Claim - Group dental claims where treatment must be preauthorized before it is performed.
   We have 15 days after receiving the appeal to notify you or your authorized representative of our appeal decision.
4) Improper or Incomplete Claim (Non-Urgent/Pre-Service) - A claim that does not include enough information for us to make a determination.
   We have 15 days after receiving the appeal to notify you or your authorized representative of our appeal decision.
5) Post-Service Health Claim - A claim that is a request for payment under the plan for covered services already received.
   We have 30 days after receiving the appeal to notify you or your authorized representative of our appeal decision.
6) Improper or Incomplete Claim (Non-Urgent/Post-Service) - A claim that does not include enough information for us to make a determination.
   We have 30 days after receiving the appeal to notify you or your authorized representative of our appeal decision.

Appeals of Adverse Benefit Determinations

Customer Service representatives are available during regular business hours to answer questions. You can reach us at 800-422-4234. If a matter cannot be resolved to your satisfaction based on a telephone call, our internal appeals process is available. This is a mandatory process. You must use our internal appeals process before taking any legal action.

Two Level Appeal Process

You or your authorized representative must file an appeal in writing and explain why you believe our initial decision was incorrect. The appeal should include the following information:

1) the name of the patient;
2) Primary Enrollee's identification number;
3) Primary Enrollee's address and daytime telephone number;
4) the name of the Client; and
5) the Dentist's name and facility location.

You may submit written comments, documents, records and other information relating to the claim even though we did not consider the information when making the initial decision. You may request, and we will provide free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim.

We will conduct the appeal without deferring to the original adverse decision. The individual who conducts the appeal will not be the person who made the initial decision or that person's subordinate. We will consult a dental care professional who has appropriate training and experience in the field of dentistry involved if dental judgment is required. The dental care professional whom we consult for the appeal will not be the person consulted in making the initial decision or that person's subordinate. Upon request, we will identify the dental professional that was consulted, whether or not we relied on his or her advice in reaching the adverse decision.

Please send an appeal of an adverse benefit determination to Dentegra at:

Quality Management Department
Attn: Appeal Review
P.O. Box 1860
Alpharetta, GA 30023

Grievances

We would like you to be completely satisfied with the dental care and services you receive, but recognize that there are times you may have questions, concerns or complaints. If you are dissatisfied with the service received from us or that of a participating Dentist, you may file a grievance with us. A grievance is a complaint about quality of care or operational issues such as waiting times at a Contract Dentist's office, adequacy of provider facilities and adequacy of the network.

Grievances should be sent to Dentegra at:

Quality Management Department
Attn: Grievance Review
P.O. Box 1860
Alpharetta, GA 30023

External Appeal

If, at the end of our internal appeal process, you are dissatisfied with the outcome, there is an external review process available. This process only applies to certain adverse benefit determinations, such as claims denials for dental necessity. The Virginia Bureau of Insurance administers this program. You must appeal our final adverse decision to the Virginia Bureau of Insurance within 30 days after that decision. To use the external review process, your out-of-pocket expenses must exceed $300.00.

The 'Office of Managed Care Ombudsman' is part of the Virginia Bureau of Insurance. One of the functions of this office is to help Virginia consumers understand and exercise their rights to appeal some adverse claim decisions. If you have any questions about an appeal or grievance involving a dental service that you received and we have not satisfactorily addressed, you may contact the Office of Managed Care Ombudsman for assistance. You may contact the office in any of the following ways.

Address:
Office of Managed Care Ombudsman
Virginia Bureau of Insurance
P. O. Box 1157
Richmond, VA 23218

Telephone Toll-Free:
877-310-6560

Richmond:
804-371-9032

Fax:
804-371-9944

Email:
ombudsman@scc.virginia.gov

Web Page:
http://www.scc.virginia.gov

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the continuation provisions described below, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;

2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;

3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or

c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Dentegra must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Dentegra will notify the Enrollee in writing, at least 30 days in advance, that Dentegra considers the dentist-patient relationships to be unsatisfactory. Dentegra will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Continuation of Coverage Following Cancellation of Enrollment

You and your dependents may be able to continue coverage with Dentegra as noted below; check with your plan administrator.

Federal COBRA

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, at your expense, if certain conditions are met. The period of continued coverage depends on the Qualifying Event. If a group is subject to COBRA continuation requirements, COBRA is the only continuation option available to an Enrollee.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:

1) you and/or your dependents who are enrolled in the Dentegra plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:

1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Dentegra within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage

for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Dentegra within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Dentegra terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Dentegra plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Delta Dental plan.

State Continuation/Conversion Options
If the Client is not eligible for federal COBRA continuation coverage, there are two options available to continue an Enrollee's dental coverage. The Client must select one of these options in writing. If the Client fails to make a selection in writing, the group will be deemed to have selected Option 1.

These options are only available if you:
1) are no longer eligible for coverage under the DeltaCare USA Contract;
2) are not eligible for Medicare or Medicaid; or
3) are not insurable under other replacement group coverage without waiting periods or preexisting conditions.

The Client will make information about these options available to you when your coverage under the group plan terminates. The group will help you enroll in the appropriate program.

OPTION 1
If the Client selects Option 1, you may elect to continue coverage under the Contract for a period of 12 months after losing eligibility under your group's dental plan. Continued coverage is available if:
1) you or your Eligible Dependents were continuously covered by the group's DeltaCare USA dental plan for at least three months immediately prior to losing coverage;
2) you apply for the continued coverage and pay the monthly premium payments to the group within 60 days from the last day of coverage under the Group plan.

The Client must remit the premiums to Delta Dental on the schedule provided for in the Contract. Premium for continuing coverage shall be at the current rate that applies to the group's coverage.

OPTION 2
If the Client selects Option 2, you may elect to convert to an individual dental plan. The coverage and premiums will be different than the group's coverage and premiums. Delta Dental will provide

a description of benefits and premiums for individual coverage upon request. Conversion coverage is made available without evidence of insurability.

Conversion coverage is available if:

1) you apply for coverage, and pay the full annual premium to Delta Dental, within 60 days of losing coverage under the group dental plan;
2) the benefits under the conversion plan do not duplicate any benefits paid for the same treatment under the group dental plan; and
3) the conversion policy extends coverage to the same family members that were covered under the group policy.

Coverage under the conversion policy is effective on the date coverage under the group plan terminates.

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $100.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5 or more years old.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5 or more years old.

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5 or more years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes: $200.00

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

D0340 2D cephalometric radiographic image - acquisition, measurement and analysis

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Dentegra. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Dentegra, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Dentegra is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedure D9944, D9945, D9946 (occlusal guards).
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. We do not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

Coverage for medically necessary health services are available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. We will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. We will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

DeltaCare USA
PO Box 1803 Alpharetta, GA 30023-1803
1-800-422-4234
deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint

Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

We provide free aids and services to people with disabilities to communicate effectively with us, such as:

- qualified sign language interpreters
- written information in other formats (large print, audio, accessible electronic formats, other formats)

We also provide free language services to people whose primary language is not English, such as:

- qualified interpreters
- information written in other languages

If you need these services, contact our Customer Service department.

Protect your oral health. Prevention is the key to avoiding tooth and gum problems. Brush and floss regularly, and visit the dentist for cleanings and exams. To learn more about prevention and avoiding dental problems, visit **mysmileway.com**. You'll find oral health articles, videos and other tools and tips for caring for your teeth. Don't forget to sign up for *Grin!*, our free dental health e-magazine.

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您能自行閱讀本文件嗎？如果不能，我們可請人幫助您閱讀。您還可以請人以您的語言撰寫本文件。如需免費幫助，請致電 1-800-422-4234 (TTY: 711)。(Chinese)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 1-800-422-4234 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-800-422-4234 (TTY: 711)번으로 연락하십시오. (Korean)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-800-422-4234 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-800-422-4234 (телетайп: 711). (Russian)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نوفر لك من يساعدك في قراءتها. ربما يمكنك أيضًا الحصول على هذا المستند مكتوبًا بلغتك للمساعدة المجانية اتصل بـ 1-800-422-4234 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-800-422-4234 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n'est pas le cas, nous pouvons faire en sorte que quelqu'un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l'assistance gratuitement, veuillez appeler le 1-800-422-4234 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-800-422-4234 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-800-422-4234 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-800-422-4234 (TTY: 711). (Italian)

この文書をお読みになれますか?お読みになれない場合には音読ボランティアを手配させていただきます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、1-800-422-4234 (TTY: 711) までお問い合わせください。(Japanese)

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 1-800-422-4234 (Schreibtelefon: 711). (German)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخواهیم تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 1-800-422-4234 (TTY: 711). (Persian Farsi)

क्या आप इस दस्तावेज़ को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी सहायता करने हेतु किसी की व्यवस्था कर सकते हैं। आप इस दस्तावेज़ को अपनी भाषा में लिखा हुआ भी प्राप्त कर सकते हैं। निशुल्क सहायता के लिए, कृपया यहाँ कॉल करें 1-800-422-4234 (TTY: 711)। (Hindi)

คุณสามารถอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย รับความชวยเหลือฟรีได้โดยโทรไปที่ 1-800-422-4234 (TTY: 711) (Thai)

LAP Tagline_CA+National_Doc_10pt_5.5x8.5_032018

ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-800-422-4234 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 1-800-422-4234 (TTY՝ 711): (Armenian)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-800-422-4234 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-800-422-4234 (TTY: 711)។ (Cambodian)

צי קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט,עמעצער דאָ קען איר העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אַז איר קענט באַקומען דעם דאָזיקן דאָקומענט אין אײַער שפּראַך. פֿאַר אומזיסטע הילף קענט איר אַנקלינגען אַט די דאָזיקע נומער: 1-800-422-4234 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'į' yídóołtahígíí nihee hóló. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaagoałdó' nich'į' ádoolnį́łgo bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojį' béésh holdíílnih 1-800-422-4234 (TTY: 711) (Navajo)

If you have any questions or need additional information, call or write:

Toll Free
800-422-4234

Administered by:

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Evidence of Coverage

WA13B

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

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Dentegra Insurance Company ("Dentegra"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Dentegra.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental") or other entity designated by Dentegra, operating as an Administrator in Washington. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Dentegra. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Authorization means the process by which Dentegra determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

Dentist means a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Domestic Partner means a person who, together with the Eligible Employee, has affirmed a domestic partnership through an affidavit of domestic partnership filed with the Client.

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

Eligible Employee means any employee or group member who is eligible for Benefits as described in this booklet.

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate attention, if failure to provide attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the Enrollee's health in serious jeopardy.

Enrollee means an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Dentegra.

We, Us or Our means Dentegra or the Administrator as appropriate.

Eligibility for Benefits

Eligible Employees and Eligible Dependents receive Benefits as soon as they are enrolled in the Program. Subject to cancellation as provided under this Program, enrollment of Eligible Employees and Eligible Dependents is for a minimum period of one year.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:
1) the date you are eligible for coverage;

2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);
2) Domestic Partner (until such partnership is terminated by either or both parties); and
3) children from birth up to the limiting age as defined by the Client.

Children include natural children, stepchildren, adopted children, foster children and children of a Domestic Partner. Newborn children (including newborn adopted children) are covered from and after the moment of birth. If additional premium is required in order to add the dependent newborn child, notice of birth and additional premium must be received within 60 days after the date of birth for coverage to continue beyond 60 days.

Legally adopted children (other than newborns) are eligible from and after the moment the Enrollee assumes legal obligation for total or partial support of the child in anticipation of adoption. If additional premium is required in order to add the dependent child, notice of placement for adoption and additional premium must be made within 60 days.

A dependent child may continue eligibility if:
1) he or she is incapable of self-sustaining employment because of a developmental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support and maintenance; and
3) proof of dependent's disability is provided within 31 days of the child's attainment of the limiting age and subsequently when requested by us, within 31 days of request. Such requests will not be made more than once a year after the two year period following the date this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

Dependents in active military service are not eligible. No Eligible Dependent may be enrolled under more than one Eligible Employee. Medicare eligibility shall not affect the eligibility of an Eligible Employee or an Eligible Dependent.

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. If your employment compensation includes this coverage, whether your employer pays all or part of the premium, you may pay the premiums as they become due directly to the Client whenever your compensation is suspended or terminated directly or indirectly as the result of a strike, lockout, or other labor dispute, for a period not exceeding six months without any change in the coverage or rates, except for normal expiration and renewal of the Contract. Such premium shall be included in the total premium paid to Dentegra as described in Section 3.01 of the Contract. After six months, if the coverage is no longer available, you may purchase an individual policy.

How to use the DeltaCare USA Program - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of

Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY US, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Dentegra terminates, that Contract Dentist will complete 1) a partial or full denture for which final impressions have been taken, and 2) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians (including a denturist operating within the lawful scope of his or her license) or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of

$100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges, up to a maximum of $50.00, over the $100.00 benefit maximum.

Emergency dental care is limited to services necessary to screen and stabilize an Enrollee. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by us. All authorized Specialist Services will be paid by us less any applicable Copayments.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments* and limitations and exclusions to determine which procedures are covered under this Program.

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be submitted to Dentegra within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for the provisions in *Emergency Services*, if you have not received Authorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated

with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Dentegra, and Dentegra may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Dentegra shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under the Contract. Dentegra shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Dentegra chooses, the amount of any Benefits paid by Dentegra which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Dentegra or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Dentegra or the Administrator, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

Quality Management Department
P.O. Box 1860
Alpharetta, GA 30023

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Dentegra

within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a clinical judgment in applying the terms of the Contract, Dentegra shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary, in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or

c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Dentegra must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Dentegra will notify the Enrollee in writing, at least 30 days in advance, that Dentegra considers the dentist-patient relationships to be unsatisfactory. Dentegra will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:

1) you and/or your dependents who are enrolled in the Dentegra plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:

1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Dentegra within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage

for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Dentegra within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Dentegra terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Dentegra plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Dentegra plan.

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999	II. PREVENTIVE	
D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $100.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes: $200.00

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

D0340 2D cephalometric radiographic image - acquisition, measurement and analysis

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Dentegra. The Enrollee pays the Copayment specified for such services.

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 the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Dentegra, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Dentegra is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

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:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures D9944, D9945, D9946 (occlusal guard).
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. We do not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

Coverage for medically necessary health services are available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. We will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. We will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

DeltaCare USA
PO Box 1803 Alpharetta, GA 30023-1803
1-800-422-4234
deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint

Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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- information written in other languages

If you need these services, contact our Customer Service department.

Protect your oral health. Prevention is the key to avoiding tooth and gum problems. Brush and floss regularly, and visit the dentist for cleanings and exams. To learn more about prevention and avoiding dental problems, visit **mysmileway.com**. You'll find oral health articles, videos and other tools and tips for caring for your teeth. Don't forget to sign up for *Grin!*, our free dental health e-magazine.

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คุณสามารถอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย รับความชวยเหลือฟรีได้โดยโทรไปที่ 1-800-422-4234 (TTY: 711) (Thai)

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ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-800-422-4234 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 1-800-422-4234 (TTY՝ 711): (Armenian)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-800-422-4234 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-800-422-4234 (TTY: 711)។ (Cambodian)

צי קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט,עמעצער דאָ קען איר העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אַז איר קענט באַקומען דעם דאָזיקן דאָקומענט אין אײַער שפּראַך. פֿאַר אומזיסטע הילף קענט איר אַנקלינגען אַט די דאָזיקע נומער: 1-800-422-4234 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'į' yídóołtahígíí nihee hóló. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaagoałdó' nich'į' ádoolnį́łgo bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojį' béésh holdíílnih 1-800-422-4234 (TTY: 711) (Navajo)

If you have any questions or need additional information, call or write:

Toll Free
800-422-4234

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Evidence of Coverage

WI13B

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

EVIDENCE OF COVERAGE

DeltaCare® USA Dental Health Care Program

This booklet is an Evidence of Coverage ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Dentegra Insurance Company ("Dentegra"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Dentegra.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental") or other entity designated by Dentegra, operating as an Administrator in the state of Wisconsin. Certain functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Dentegra. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-422-4234.

Authorization means the process by which Dentegra determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

Dentist means a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

Eligible Employee means any employee or group member who is eligible for Benefits as described in this booklet.

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

Enrollee means an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Dentegra.

We, Us or Our means Dentegra or the Administrator as appropriate.

Eligibility for Benefits

Eligible Employees and Eligible Dependents receive Benefits as soon as they are enrolled in the Program. Subject to cancellation as provided under this Program, enrollment of Eligible Employees and Eligible Dependents is for a minimum period of one year.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:

1) spouse (unless legally separated or divorced);

2) unmarried children from birth up to the limiting age as defined by the Client; and
3) unmarried children beyond the limiting age. Such dependents must be Full-Time Students and wholly dependent on you for support.

Children include natural children, stepchildren, grandchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newly adopted children) are covered from and after the moment of birth or from the moment the child is placed for adoption. If additional premium is required in order to add the dependent child, notice of birth or placement and additional premium must be received within 60 days after the date of birth or placement for coverage to continue beyond 60 days. We may refuse to continue coverage beyond the 60-day period if such notification is not received, unless within one year after the birth or placement of the child, the Primary Enrollee makes all past-due payments and in addition pays interest on such payments at the rate of 5 percent per year.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

Dependents in active military service are not eligible. No Eligible Dependent may be enrolled under more than one Eligible Employee. Medicare eligibility shall not affect the eligibility of an Eligible Employee or an Eligible Dependent.

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire

to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY US, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Dentegra terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by us. All authorized Specialist Services will be paid by us less any applicable Copayments.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments*, and

the limitations and exclusions to determine which procedures are covered under this Program.

Quality Assurance

The Plan's Quality Management Program (QMP) was established according to the guidelines set forth by the Centers for Disease Control and the American Dental Association. Additionally, QMP complies with the guidelines of the Health Care Finance Administration (HCFA) regarding complaints for Medicare enrollees.

The Quality Management Program is the cornerstone of the Plan's commitment to its members and provider panel. As administrator of the Plan, Delta Dental Insurance Company ("Delta Dental") is responsible for exercising oversight of the quality of care that is provided by the dentist participating on the Plan's panel.

Facility Review Process

All applicants for participation as a Contract Dentist, whose credentials are approved, will receive a pre-contract audit of their dental facility. The facility review evaluates the size, physical appearance and the general adequacy of the dental office to provide quality care. Each Contract Dentist's facility will be subject to review of patient records by a dental consultant to assess the quality of care rendered to Enrollees.

Patient Surveys

The Quality Management Review Committee ("QMRC") regularly uses patient satisfaction surveys as an aid in identifying quality of care issues. Each month, approximately 500 randomly selected Enrollees receive a questionnaire by mail to aid in the QMRC's assessment of their experiences in receiving care from Contract Dentists. These enrollees are asked to comment on such issues as waiting time, accessibility, courtesy of the office staff, attentiveness to the patient's needs and perceived quality of care. Patients are also asked to write comments or to supply additional information in the "comments" section of the survey.

Second Opinions

Second opinions will be rendered by a licensed Dentist in a timely manner appropriate to the nature of the Enrollee's condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes

for second opinion authorizations, the Enrollee should contact the Customer Service department at 800-422-4234.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Dentegra. Dentegra will authorize a second opinion by an out-of-network provider if an appropriately qualified Contract Dentist is not available. Dentegra will only pay for a second opinion which Dentegra has approved or authorized. The Enrollee will be sent a written notification should Dentegra decide not to authorize a second opinion. If the Enrollee disagrees with this determination, the Enrollee may file a grievance with the plan or with the Office of the Commissioner of Insurance. Refer to *Article 6* for information on Enrollee Complaint Procedures.

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services must be sent within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if Dentegra is not prejudiced by the late receipt of the claim and the Enrollee can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us.

Except for the provisions in *Emergency Services*, if you have not received Authorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

For further clarification, refer to the provisions for *Emergency Services* and *Specialist Services*.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Dentegra, and Dentegra may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Dentegra shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under the Contract. Dentegra shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Dentegra chooses, the amount of any Benefits paid by Dentegra which exceeds its obligations under these coordination of benefit provisions.

Enrollee Grievance Procedure

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Customer Service
P.O. Box 1860
Alpharetta, Georgia 30023
800-422-4234

You can also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the OFFICE OF THE COMMISSIONER OF INSURANCE by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
800-236-8517
608-266-0103

"Grievance" means any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan

or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an Enrollee.

Dentegra or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If an Enrollee has any grievance regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Dentegra or the Administrator, or the quality of dental services performed by a Contract Dentist, he or she may call the Customer Service department at 800-422-4234, or the Grievance may be addressed in writing to:

Quality Management Department
P.O. Box 1860
Alpharetta, Georgia 30023

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Applicant and 4) the Dentist's name and facility location.

For Grievances involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) the Enrollee must file a request for review with Dentegra. Dentegra's review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Dentegra shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

Within 5 business days of the receipt of any Grievance, including adverse benefit determinations as described above, the quality management coordinator will forward to the grievant an acknowledgment of receipt of the Grievance. Certain Grievances may require that the grievant 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 Grievance or shall provide a written explanation if an additional 30 days is required to resolve the Grievance.

If a Grievance involves severe pain and imminent and serious threat to an Enrollee's health, the Grievance may be eligible for expedited review. An expedited Grievance shall be resolved as expeditiously as the health condition requires, but not more than 72 hours after receipt of the Grievance.

An Enrollee who has filed a Grievance, including a Grievance regarding an adverse benefit determination, or the Enrollee's authorized representative, has the right to appear in person before a Grievance panel to present written or oral information. Dentegra will permit the grievant to submit written questions to the person or persons responsible for making the determination that resulted in the denial, determination, or initiation of disenrollment unless Dentegra permits the Enrollee, or the Enrollee's authorized representative to meet with and question the decision maker or makers. A written notification of the time and place of the Grievance meeting will be sent to the Enrollee at least 7 calendar days before the meeting.

The Grievance panel shall consist of at least three individuals, including no more than one subordinate of the person who made the initial determination. The Enrollee member of the panel will not be an employee of Dentegra, or the Administrator. If appropriate, the Grievance panel shall consult with a licensed Dentist with expertise in the field relating to the Grievance. The panel's written decision will be sent to the insured in a timely fashion and will be signed by one voting member of the panel.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. The Enrollee may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the

Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Optional Continuation of Coverage* provision, an Eligible Employee's or Eligible Dependent's enrollment under this Program may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage; or
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due, or within the 31 day premium grace period. However the Enrollee may continue to receive Benefits during the 31-day period and may be reinstated during the term of this Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
   c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Dentegra must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Dentegra will notify the Enrollee in writing, at least 30 days in advance, that Dentegra considers the dentist-patient relationships to be unsatisfactory. Dentegra will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Entire Agreement

The Contract, the Contract application, and any attached schedules, appendices, endorsements and riders, constitute the entire agreement between Dentegra and Applicant. All statements made by the Applicant or by any persons covered shall be deemed representations and not warranties. No agent has authority to amend this Contract or waive any of its provisions. No amendment to this Contract shall be valid unless approved by an executive officer of Dentegra and evidenced by endorsements. Any amendment which reduces or eliminates coverage shall have been either requested in writing or signed by the Applicant.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:

1) you and/or your dependents who are enrolled in the Dentegra plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 60 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:

1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Dentegra within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage

for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Dentegra within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Dentegra terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Dentegra plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Dentegra plan.

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $100.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5 or more years old.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5 or more years old.

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5 or more years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes: $200.00

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

D0340 2D cephalometric radiographic image - acquisition, measurement and analysis

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Dentegra. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Dentegra, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Dentegra is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. We do not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

Coverage for medically necessary health services are available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. We will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. We will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

DeltaCare USA
PO Box 1803 Alpharetta, GA 30023-1803
1-800-422-4234
deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint

Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

We provide free aids and services to people with disabilities to communicate effectively with us, such as:

- qualified sign language interpreters
- written information in other formats (large print, audio, accessible electronic formats, other formats)

We also provide free language services to people whose primary language is not English, such as:

- qualified interpreters
- information written in other languages

If you need these services, contact our Customer Service department.

Protect your oral health. Prevention is the key to avoiding tooth and gum problems. Brush and floss regularly, and visit the dentist for cleanings and exams. To learn more about prevention and avoiding dental problems, visit **mysmileway.com**. You'll find oral health articles, videos and other tools and tips for caring for your teeth. Don't forget to sign up for *Grin!*, our free dental health e-magazine.

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이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-800-422-4234 (TTY: 711)번으로 연락하십시오. (Korean)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-800-422-4234 (TTY: 711). (Tagalog)

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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)

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ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-800-422-4234 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 1-800-422-4234 (TTY՝ 711): (Armenian)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-800-422-4234 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-800-422-4234 (TTY: 711)។ (Cambodian)

צי קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט,עמעצער דאָ קען איר העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אַז איר קענט באַקומען דעם דאָזיקן דאָקומענט אין אײַער שפּראַך. פֿאַר אומזיסטע הילף קענט איר אַנקלינגען אַט די דאָזיקע נומער: 1-800-422-4234 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'į' yídóołtahígíí nihee hóló. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaagoałdó' nich'į' ádoolnį́łgo bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojį' béésh holdíílnih 1-800-422-4234 (TTY: 711) (Navajo)

If you have any questions or need additional information, call or write:

Toll Free
800-422-4234

Customer Service Department
P.O. Box 1803
Alpharetta, GA 30023

DeltaCare® USA

Dental Health Care Program for
Eligible Employees and Dependents

Combined Evidence of Coverage and Disclosure Form

WV13B

Provided by:
Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009
800-422-4234

deltadentalins.com

EVIDENCE OF COVERAGE

DISCLOSURE FORM

DeltaCare® USA Dental Health Care Program

This booklet is a Combined Evidence of Coverage and Disclosure Form ("EOC") for your DeltaCare USA Dental Health Care Program ("Program") provided by Delta Dental Insurance Company ("Delta Dental"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Delta Dental.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

As used in this booklet:

Administrator means Delta Dental Insurance Company ("Delta Dental"), or other entity designated by Delta Dental, operating as an Administrator in the State of West Virginia. Administrative functions described in the Contract and in this booklet may be performed by the Administrator, as designated by Delta Dental. The mailing address for Delta Dental is P.O. Box 1803, Alpharetta, GA 30023. Delta Dental will answer calls directed to 800-422-4234.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

Contract Specialist means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

Dentist means a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

Eligible Employee means any employee or group member who is eligible for Benefits as described in this booklet.

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or

immediately required to avoid placing the Enrollee's health in serious jeopardy.

Enrollee means an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

Preauthorization means the process by which Delta Dental determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Specialist Services means services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be preauthorized by the Administrator.

We, Us or Our means Delta Dental or the Administrator as appropriate.

Eligibility for Benefits

Eligible Employees and Eligible Dependents receive Benefits as soon as they are enrolled in the Program. Subject to cancellation as provided under this Program, enrollment of Eligible Employees and Eligible Dependents is for a minimum period of one year.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:
1) the date you are eligible for coverage;
2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:
1) spouse (unless legally separated or divorced);
2) unmarried children from birth up to the limiting age as defined by the Client; and

3) unmarried children beyond the limiting age. Such dependents must be Full-Time Students and wholly dependent on you for support.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Legally adopted children (other than newborns) are eligible during and after the period of probation.

An unmarried dependent child may continue eligibility if:
1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on you for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

The dependent child is not required to reside with a parent or legal guardian who is an Enrollee.

Dependents in active military service are not eligible. No Eligible Dependent may be enrolled under more than one Eligible Employee. Medicare eligibility shall not affect the eligibility of an Eligible Employee or an Eligible Dependent.

Premiums

This Program requires premiums to be paid to us. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly. The Client will be responsible for sending all payments of premiums to us except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Plan - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a DeltaCare USA membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of Dentists should be directed to the Customer Service department at 800-422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED BY THE ADMINISTRATOR, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Delta Dental terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call the Customer Service department at 800-422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of $100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the $100.00 benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and preauthorized by the Administrator. All preauthorized Specialist Services will be paid by us less any applicable Copayments.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments*, and the limitations and exclusions to determine which procedures are covered under this Program.

Claims for Reimbursement

Claims for covered Emergency Services or preauthorized Specialist Services must be submitted to the Administrator within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. The address for claims submission is: Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

In the event that we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. Except for the provisions in *Emergency Services*, if you have not received Preauthorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Delta Dental, and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an

insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Delta Dental shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefits paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Delta Dental shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the quality of dental services performed by a Contract Dentist, you may call the Customer Service department at 800-422-4234, or the complaint may be addressed in writing to:

Quality Management Department
P.O. Box 1860
Alpharetta, Georgia 30023

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Delta Dental within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is

involved in the review, the identity of such consulting Dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you 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 shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall 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 shall undertake a full and fair review upon request. We may require additional documents, as we deem necessary, in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to the *Enrollee Complaint Procedure*, or the *Optional Continuation of Coverage* provision, an Eligible Employee's or

Eligible Dependent's enrollment under this Program may be cancelled, or renewal of enrollment refused, in the following events:

1) Immediately:
   a) upon loss of eligibility as described in this Evidence of Coverage, however, an employee who loses coverage under this plan because he or she is involuntarily laid off from work may continue coverage for a period not to exceed 18 months;
   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) Upon 15 days written notice if:
   a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of the Contract upon payment of any unpaid premium; or
   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Program;
3) Upon 30 days written notice if:
   a) the Contract is terminated or not renewed;
   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of the Contract upon payment of all delinquent charges; or
   c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Delta Dental must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Delta Dental will notify the Enrollee in writing, at least 30 days in advance, that Delta Dental considers the dentist-patient relationships to be unsatisfactory. Delta Dental will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section is shown below.

Qualified Beneficiary means:
1) you and/or your dependents who are enrolled in the Delta Dental plan on the day before the Qualifying Event, or
2) a child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1.	the termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;
Event 2.	your death;
Event 3.	your divorce or legal separation from your spouse;
Event 4.	your dependent's loss of dependent status under the plan; and
Event 5.	as to your dependents only, your entitlement to Medicare.

You or **your** means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18-month period can be extended for a total of 29 months, provided:
1) a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2) notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination

that the disabled individual is no longer disabled. You must notify your employer or Delta Dental within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

Your employer shall notify Delta Dental within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4 or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give his or her employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her

employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continue coverage and any premium received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1) the allowable number of consecutive months of continued coverage is reached;
2) failure to pay the required premiums in a timely manner;
3) the employer ceases to provide any group dental plan to its employees;
4) the individual moves out of the plan's service area;
5) the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6) entitlement to Medicare.

The employer shall notify Delta Dental within 30 days of the occurrence of any of the above events. Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta Dental terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Delta Dental plan had such plan with

the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Delta Dental plan.

OPTIONAL CONTINUATION OF COVERAGE - MINI COBRA FOR SMALL EMPLOYERS

Continuation of Coverage - Mini COBRA for Small Employers
An Enrollee who is employed or covered by a small employer, which is defined by West Virginia 114-93-2.9, as an employer - not subject to COBRA because it has less than 20 employees, and whose coverage under this Contract ends may continue coverage under the employer's company Contract for up to 18 additional months provided the Primary Enrollee's coverage was involuntarily terminated due to lay-off or reason other than misconduct.

Enrollees who wish to continue coverage must send Delta Dental a notice of intent to continue coverage within 20 days of the Primary Enrollee being involuntarily terminated due to lay-off or reason other than misconduct. The notice must be sent to Delta Dental's administrator of mini-COBRA for small employers at the below address and must include at a minimum the name of the covered employee, the company's name, the group number, and the names and addresses of the Enrollees wishing to continue coverage.

Wolfpack Insurance Services Inc.
P.O. Box 833
Belmont, CA 94002-0833

Within 15 days of receiving an Enrollee's notice of intent to continue coverage, the administrator will send adult Enrollees an election and premium form. Enrollees must return the completed election and premium form and initial premium within 30 days to the

administrator at the above address. The administrator will bill Enrollees who continue coverage on a monthly basis. Such Enrollees have a 30 day grace period for payment of premium.

An Enrollee's continued coverage ends the earlier of the following:
- the end of the Grace Period if premiums are not paid on time;
- the Enrollee becomes eligible for similar group coverage;
- the Enrollee performs an act or practice that constitutes fraud in connection with the coverage;
- the end of the 18 months; or
- this group Contract terminates.

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost

D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$5.00

D1000-D1999	II. PREVENTIVE	
D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$40.00
D1516	Space maintainer - fixed - bilateral, maxillary	$40.00
D1517	Space maintainer - fixed - bilateral, mandibular	$40.00
D1520	Space maintainer - removable - unilateral - per quadrant	$50.00
D1526	Space maintainer - removable - bilateral, maxillary	$50.00
D1527	Space maintainer - removable - bilateral, mandibular	$50.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$10.00

D1557	Removal of fixed bilateral space maintainer - maxillary	$10.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$10.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$40.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $100.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$55.00
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	$145.00
D2520	Inlay - metallic - two surfaces	$155.00
D2530	Inlay - metallic - three or more surfaces	$165.00
D2542	Onlay - metallic - two surfaces	$160.00
D2543	Onlay - metallic - three surfaces	$170.00
D2544	Onlay - metallic - four or more surfaces	$190.00
D2610	Inlay - porcelain/ceramic - one surface	$270.00
D2620	Inlay - porcelain/ceramic - two surfaces	$305.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$325.00

D2642	Onlay - porcelain/ceramic - two surfaces	$300.00
D2643	Onlay - porcelain/ceramic - three surfaces	$335.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$355.00
D2650	Inlay - resin-based composite - one surface	$170.00
D2651	Inlay - resin-based composite - two surfaces	$195.00
D2652	Inlay - resin-based composite - three or more surfaces	$230.00
D2662	Onlay - resin-based composite - two surfaces	$225.00
D2663	Onlay - resin-based composite - three surfaces	$250.00
D2664	Onlay - resin-based composite - four or more surfaces	$295.00
D2710	Crown - resin-based composite (indirect)	$145.00
D2712	Crown - 3/4 resin-based composite (indirect)	$145.00
D2720	Crown - resin with high noble metal	$295.00
D2721	Crown - resin with predominantly base metal	$195.00
D2722	Crown - resin with noble metal	$235.00
D2740	Crown - porcelain/ceramic	$355.00
D2750	Crown - porcelain fused to high noble metal	$355.00
D2751	Crown - porcelain fused to predominantly base metal	$255.00
D2752	Crown - porcelain fused to noble metal	$295.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$355.00
D2780	Crown - 3/4 cast high noble metal	$355.00
D2781	Crown - 3/4 cast predominantly base metal	$255.00
D2782	Crown - 3/4 cast noble metal	$295.00
D2783	Crown - 3/4 porcelain/ceramic	$355.00
D2790	Crown - full cast high noble metal	$355.00
D2791	Crown - full cast predominantly base metal	$255.00
D2792	Crown - full cast noble metal	$295.00
D2794	Crown - titanium and titanium alloys	$355.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$45.00

D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$50.00
D2931	Prefabricated stainless steel crown - permanent tooth	$50.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$65.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	$50.00
D2950	Core buildup, including any pins when required	$50.00
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$95.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$70.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$80.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$60.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$25.00

D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$25.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$95.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$125.00
D3347	Retreatment of previous root canal therapy - premolar	$215.00
D3348	Retreatment of previous root canal therapy - molar	$365.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	$115.00
D3421	Apicoectomy - premolar (first root)	$125.00
D3425	Apicoectomy - molar (first root)	$135.00
D3426	Apicoectomy (each additional root)	$80.00
D3427	Periradicular surgery without apicoectomy	$115.00
D3430	Retrograde filling - per root	$60.00

D3450	Root amputation - per root	$70.00
D3920	Hemisection (including any root removal), not including root canal therapy	$60.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$135.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$125.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$215.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$65.00
D4270	Pedicle soft tissue graft procedure	$215.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$215.00

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	$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$50.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$40.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$50.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$35.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	$285.00
D5120	Complete denture - mandibular	$285.00
D5130	Immediate denture - maxillary	$305.00
D5140	Immediate denture - mandibular	$305.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$245.00

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/ clasping materials, rests and teeth)	$315.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$245.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$315.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denture base, maxillary	$40.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$20.00
D5611	Repair resin partial denture base, mandibular	$40.00
D5612	Repair resin partial denture base, maxillary	$40.00
D5621	Repair cast partial framework, mandibular	$40.00
D5622	Repair cast partial framework, maxillary	$40.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40.00
D5640	Replace broken teeth - per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture - per tooth	$40.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$95.00
D5711	Rebase complete mandibular denture	$95.00
D5720	Rebase maxillary partial denture	$95.00
D5721	Rebase mandibular partial denture	$95.00
D5730	Reline complete maxillary denture (chairside)	$50.00
D5731	Reline complete mandibular denture (chairside)	$50.00
D5740	Reline maxillary partial denture (chairside)	$50.00
D5741	Reline mandibular partial denture (chairside)	$50.00
D5750	Reline complete maxillary denture (laboratory)	$85.00
D5751	Reline complete mandibular denture (laboratory)	$85.00
D5760	Reline maxillary partial denture (laboratory)	$85.00
D5761	Reline mandibular partial denture (laboratory)	$85.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$105.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$105.00
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00

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, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$355.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$295.00
D6240	Pontic - porcelain fused to high noble metal	$355.00
D6241	Pontic - porcelain fused to predominantly base metal	$255.00
D6242	Pontic - porcelain fused to noble metal	$295.00

D6243	Pontic - porcelain fused to titanium and titanium alloys	$295.00
D6245	Pontic - porcelain/ceramic	$355.00
D6250	Pontic - resin with high noble metal	$295.00
D6251	Pontic - resin with predominantly base metal	$195.00
D6252	Pontic - resin with noble metal	$235.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$305.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$255.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$265.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$155.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$165.00
D6606	Retainer inlay - cast noble metal, two surfaces	$185.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$195.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$300.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$260.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$270.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$160.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$170.00
D6614	Retainer onlay - cast noble metal, two surfaces	$190.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200.00
D6720	Retainer crown - resin with high noble metal	$295.00
D6721	Retainer crown - resin with predominantly base metal	$195.00
D6722	Retainer crown - resin with noble metal	$235.00
D6740	Retainer crown - porcelain/ceramic	$355.00

D6750	Retainer crown - porcelain fused to high noble metal	$355.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$255.00
D6752	Retainer crown - porcelain fused to noble metal	$295.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$355.00
D6780	Retainer crown - 3/4 cast high noble metal	$355.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$255.00
D6782	Retainer crown - 3/4 cast noble metal	$295.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$355.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	$355.00
D6790	Retainer crown - full cast high noble metal	$355.00
D6791	Retainer crown - full cast predominantly base metal	$255.00
D6792	Retainer crown - full cast noble metal	$295.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$55.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Removal of residual tooth roots (cutting procedure)	$35.00
D7251	Coronectomy - intentional partial tooth removal	$115.00

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
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)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$70.00
D7971	Excision of pericoronal gingiva	$70.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of

active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes: $200.00

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

D0340 2D cephalometric radiographic image - acquisition, measurement and analysis

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition $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

D8050 Interceptive orthodontic treatment of the primary dentition $1,150.00

D8060 Interceptive orthodontic treatment of the transitional dentition $1,150.00

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
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
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	$10.00
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost

D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$45.00
D9952	Occlusal adjustment, complete	$95.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide specialized services, and are referred by the assigned Contract Dentist, must be preauthorized by the Administrator. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Non-Discrimination Disclosure

Discrimination Is Against the Law

We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. We do not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

Coverage for medically necessary health services are available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. We will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. We will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a customer service representative, or by mail.

DeltaCare USA
PO Box 1803 Alpharetta, GA 30023-1803
1-800-422-4234
deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint

Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

We provide free aids and services to people with disabilities to communicate effectively with us, such as:

- qualified sign language interpreters
- written information in other formats (large print, audio, accessible electronic formats, other formats)

We also provide free language services to people whose primary language is not English, such as:

- qualified interpreters
- information written in other languages

If you need these services, contact our Customer Service department.

Protect your oral health. Prevention is the key to avoiding tooth and gum problems. Brush and floss regularly, and visit the dentist for cleanings and exams. To learn more about prevention and avoiding dental problems, visit **mysmileway.com**. You'll find oral health articles, videos and other tools and tips for caring for your teeth. Don't forget to sign up for *Grin!*, our free dental health e-magazine.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call 1-800-422-4234 (TTY: 711).

¿Puede leer este documento? Si no, podemos encontrar a alguien que lo ayude a leerlo. También puede obtener este documento escrito en su idioma. Para obtener ayuda gratuita, llame al 1-800-422-4234 (servicio de retransmisión TTY deben llamar al 711). (Spanish)

您能自行閱讀本文件嗎？如果不能，我們可請人幫助您閱讀。您還可以請人以您的語言撰寫本文件。如需免費幫助，請致電 1-800-422-4234 (TTY: 711)。(Chinese)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 1-800-422-4234 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-800-422-4234 (TTY: 711)번으로 연락하십시오. (Korean)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-800-422-4234 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-800-422-4234 (телетайп: 711). (Russian)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نوفر لك من يساعدك في قراءتها. ربما يمكنك أيضًا الحصول على هذا المستند مكتوبًا بلغتك للمساعدة المجانية اتصل بـ 1-800-422-4234 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-800-422-4234 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n'est pas le cas, nous pouvons faire en sorte que quelqu'un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l'assistance gratuitement, veuillez appeler le 1-800-422-4234 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-800-422-4234 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-800-422-4234 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-800-422-4234 (TTY: 711). (Italian)

この文書をお読みになれますか?お読みになれない場合には音読ボランティアを手配させていただきます。この文書をご希望の言語に訳したものをお送りできる場合もあります。無料のサポートについては、1-800-422-4234 (TTY: 711) までお問い合わせください。(Japanese)

Können Sie dieses Dokument lesen? Falls nicht, können wir Ihnen einen Mitarbeiter zur Verfügung stellen, der Sie dabei unterstützen wird. Möglicherweise können Sie dieses Dokument auch in Ihrer Sprache erhalten. Rufen Sie für kostenlose Hilfe bitte folgende Nummer an: 1-800-422-4234 (Schreibtelefon: 711). (German)

آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخواهیم تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 1-800-422-4234 (TTY: 711). (Persian Farsi)

क्या आप इस दस्तावेज़ को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी सहायता करने हेतु किसी की व्यवस्था कर सकते हैं। आप इस दस्तावेज़ को अपनी भाषा में लिखा हुआ भी प्राप्त कर सकते हैं। निशुल्क सहायता के लिए, कृपया यहाँ कॉल करें 1-800-422-4234 (TTY: 711)। (Hindi)

คุณสามารถอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย รับความชวยเหลือฟรีได้โดยโทรไปที่ 1-800-422-4234 (TTY: 711) (Thai)

LAP Tagline_CA+National_Doc_10pt_5.5x8.5_032018

ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-800-422-4234 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Դուք կարո՞ղ եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրված ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել 1-800-422-4234 (TTY՝ 711): (Armenian)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-800-422-4234 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-800-422-4234 (TTY: 711)។ (Cambodian)

צי קענט איר לייענען דעם דאָזיקן דאָקומענט? אויב ניט,עמעצער דאָ קען איר העלפֿן אים צו לייענען. עס איז אויך מעגלעך, אַז איר קענט באַקומען דעם דאָזיקן דאָקומענט אין אײַער שפּראַך. פֿאַר אומזיסטע הילף קענט איר אַנקלינגען אַט די דאָזיקע נומער: 1-800-422-4234 ס'איז דאָ אַ נומער פֿאַר מענטשען, וואָס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bíníghah? Doo bíníghahgóó éí nich'į' yídóołtahígíí nihee hóló. Díí naaltsoos t'áá Diné bizaad k'ehjí ályaagoałdó' nich'į' ádoolnį́łgo bíighah. T'áá jíík'e shíká i'doolwoł nínízingo kojį' béésh holdíílnih 1-800-422-4234 (TTY: 711) (Navajo)

If you have any questions or need additional information, call or write:

Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

800-422-4234

Delta Dental Insurance Company

CLUBCORP USA, INC.



deltadentalins.com

Group No: 05813

Effective Date: January 1, 2021

DELTA DENTAL INSURANCE COMPANY
1130 Sanctuary Parkway
Alpharetta, Georgia 30009
(770) 641-5100
(800) 521-2651

CERTIFICATE OF COVERAGE
OF YOUR GROUP DENTAL PROGRAM

This booklet is a summary of your group dental program. Please read it carefully. It only summarizes the detailed provisions of the group dental contract issued by **Delta Dental Insurance Company** (**"Delta Dental"**) and cannot modify the Contract in any way.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.



Michael G. Hankinson, Esq., President

TEXAS NOTICE OF COMPLAINT

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Delta Dental Insurance Company's toll free number for information or to make a complaint at

1-800-521-2651

You may also write to Delta Dental Insurance Company at

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, Georgia 30009

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at

1-800-252-3439

You may write the Texas Department of Insurance at

P.O. Box 149104
Austin TX 78714-9104
FAX # (512) 475-1771

Web http://www.tdi.state.tx.us

E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim, you should contact your agent or Delta Dental Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefon gratis de Delta Dental Insurance Company para informacion o para someter una queja al

1-800-521-2651

Usted tambien puede escribir a Delta Dental Insurance Company

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, Georgia 30009

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin TX 78714-9104
FAX # (512) 475-1771

Web http://www.tdi.state.tx.us

E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:
Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o Delta Dental Insurance Company primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:
Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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GROUP HIGHLIGHTS

PLAN:
You have a Calendar Year plan and deductibles and maximums will be based upon a Calendar Year, which is January 1st through December 31st.

BENEFITS:

	In-Network	*Out-of-Network*
Diagnostic and Preventive Benefits:	100%	100%
Basic Benefits:	80%	80%
Major Benefits:	50%	50%

DEDUCTIBLE:
For each Enrollee per Calendar Year is $50.
For all family members per Calendar Year is $150.

The deductible does not apply to Diagnostic and Preventive Benefits.

MAXIMUM:
The maximum payable each Calendar Year for Benefits is $1,500 per Enrollee.

PREMIUMS:
You are required to contribute towards the cost of your coverage.
You are required to contribute towards the cost of your Dependent's coverage.

Delta Dental may cancel this Program 31 days after written notice to the Contractholder if monthly premiums are not paid when due.

DEFINITIONS

Terms when capitalized in your certificate of insurance booklet have defined meanings, given in the section below or throughout the booklet sections.

Approved Amount -- the maximum amount a Dentist may charge for a Single Procedure.

Benefits (In-Network or Out-of-Network) -- the amounts that Delta Dental will pay for dental services under the Contract. In-Network Benefits are those covered by the Contract and performed by a DPO Dentist. Out-of-Network Benefits are those covered by the Contract but performed by a Delta Dental Premier® Dentist or Non-Delta Dental Dentist.

Claim Form -- the standard form used to file a claim or request Pre-Treatment Estimate for treatment.

Contract -- the written agreement under which Benefits are provided.

Contract Allowance -- the maximum amount Delta Dental will use for calculating Benefits for a Single Procedure. The Contract Allowance for services provided:

- by DPO Dentists is the lesser of the Dentist's submitted fee, the DPO Dentist's Fee or the approved amount as outlined in the terms of the Contracting Dentist Agreement with Delta Dental.
- by Delta Dental Premier® Dentists (who are not DPO Dentists) is the lesser of the Dentist's submitted fee, the approved amount as outlined in the terms of the Contracting Dentist Agreement with Delta Dental or Maximum Plan Allowance.
- by Non-Delta Dental Dentists is the lesser of the Dentist's submitted fee or the Maximum Plan Allowance.

Contractholder -- the employer, union or other organization or group contracting to obtain Benefits.

Contracting DPO Dentist Agreement (DPO Dentist Agreement) -- an agreement between a member of the Delta Dental Plans Association and a Dentist which establishes the terms and conditions under which covered services are provided under a DPO program.

Contracting Dentist Agreement -- an agreement between a member of the Delta Dental Plans Association and a Dentist that establishes the terms and conditions under which services are provided.

DPO Dentist -- a contracting Delta Dental Dentist who agrees to accept DPO Dentist's Fees as payment in full and complies with Delta Dental's administrative guidelines. All DPO Dentists are also Delta Dental Premier Dentists. All DPO Dentists must be contracted in the Premier network.

DPO Dentist's Fee -- the fee outlined in the DPO Dentist Agreement. DPO Dentists agree to charge no more than this fee for treating DPO Enrollees.

Delta Dental Premier Dentist (Premier Dentist) -- a Dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and who agrees to abide by certain administrative guidelines. Not all Premier Dentists are DPO Dentists; however, all Premier Dentists agree to accept Delta Dental's Maximum Plan Allowance for each Single Procedure as payment in full.

DPO -- a Dental Provider Organization.

Dentist -- a person licensed to practice dentistry when and where services are performed.

Dependent Enrollee -- a dependent of a Primary Enrollee who is eligible for Benefits under the Contract.

Effective Date -- the date the program starts. This date is given on the booklet cover.

Enrollee -- a Primary Enrollee or Dependent Enrollee enrolled to receive Benefits.

Maximum Plan Allowance (MPA) -- the maximum amount Delta Dental will reimburse for a covered procedure. Delta Dental establishes the MPA for each procedure through a review of proprietary filed fee data and actual submitted claims. MPAs are set annually to reflect charges based on actual submitted claims from providers in the same geographical area with similar professional standing. The MPA may vary by the type of contracting Dentist.

Non-Delta Dental Dentist -- a Dentist who is neither a Premier nor a DPO Dentist and who is not contractually bound to abide by Delta Dental's administrative guidelines.

Open Enrollment Period -- the period 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 patient is eligible.

Primary Enrollee -- any employee eligible for Benefits under the Contract.

Procedure Code -- the Current Dental Terminology (CDT) number assigned to a Single Procedure by the American Dental Association.

Qualifying Status Change -- a change in:

- legal marital status (marriage, divorce, annulment or death);
- number of dependents (a child's birth, adoption of a child, Eligible Person becomes party in a suit to adopt a child, addition of a step or foster child or eligible grandchild or death of a child);
- employment status (change in employment status of Enrollee, spouse or dependent child);
- dependent child ceases to satisfy eligibility requirements (limiting age, student status or marital status);
- residence (Enrollee, dependent spouse or child moves);
- a court order requiring dependent coverage; or
- any other current or future election changes permitted by IRC Section 125.

Single Procedure -- a dental procedure that is assigned a separate CDT number.

CHOICE OF DENTIST

Delta Dental offers a choice of selecting a Dentist from our panel of DPO Dentists and Premier Dentists, or you may choose a Non-Delta Dental Dentist. A list of Delta Dental Dentists can be obtained by accessing the Delta Dental National Dentist Directory at deltadentalins.com. You are responsible for verifying whether the Dentist you select is a DPO Dentist or a Premier Dentist. Dentists are regularly added to the panel. Additionally, you should always confirm with the dentist's office that a listed Dentist is still a contracted DPO Dentist or a Premier Dentist.

DPO Dentist
The DPO program potentially allows you the greatest reduction in your out-of-pocket expenses, since this select group of Dentists in your area will provide dental Benefits at a charge which has been contractually agreed upon between Delta Dental and the DPO Dentist.

Premier Dentist
The Premier Dentist has not agreed to the features of the DPO program; however, you may still receive dental care at a lower cost than if you use a Non-Delta Dental Dentist.

Non-Delta Dental Dentist
If a Dentist is a Non-Delta Dental Dentist, the amount charged to you may be above that accepted by the DPO or Premier Dentists. Non-Delta Dental Dentists can balance bill for the difference between the MPA and the Non-Delta Dental Dentist's Approved Amount. For a Non-Delta Dental Dentist, the Approved Amount is the dentist's submitted charge.

Additional advantages of using a DPO Dentist or Premier Dentist
- The DPO Dentist and Premier Dentist must accept assignment of Benefits, meaning DPO Dentists and Premier Dentists will be paid directly by Delta Dental after satisfaction of the deductible and coinsurance, and the Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The DPO Dentist and Premier Dentist will complete the dental claim form and submit it to Delta Dental for reimbursement.

WHO IS ELIGIBLE?

Eligibility for Enrollment
All present regular full-time employees of the Contractholder working a minimum of 30 hours per week are eligible on the Effective Date.

All regular full-time employees of the Contractholder working a minimum of 30 hours per week will become eligible on the first day upon completion of 6 months of consecutive service from date of hire.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents. Dependents are your:
- Lawful spouse.
- Unmarried dependent children from birth to their 25th birthday. "Children" includes natural children, step-children, adopted children and foster children with no distinction made based on the marital status or lack of marital status between the Eligible Person and the other parent. Newborn infants are eligible from the moment of birth. An adopted child will be eligible from the moment the Eligible Person becomes a party in a suit to adopt the child. A newborn child or adopted child will automatically be covered for 31 days. To continue coverage after 31 days, notice of the birth or notice regarding the suit to adopt and additional Premium, if any, must be received within the 31 day period.
- Unmarried grandchildren who are less than 25 years of age and are a dependent of the Eligible Person for federal income tax purposes at the time application for coverage of the grandchild is made. Coverage for said grandchild may not be terminated solely because the grandchild is no longer dependent upon the Eligible Person for federal income tax purposes.
- Unmarried dependent children, including grandchildren, under 25 years of age for whom the Eligible Person is required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court in Texas. Said child may request to be covered under the Eligible Person's coverage.
- An unmarried child, including grandchild, 25 years of age or older who is not self-supporting because of mental retardation or physical handicap and the child is chiefly dependent upon the Eligible Person for support and maintenance. Proof of these facts must be given to Delta Dental within 31 days of the child's attainment of age 25. Proof will not be required more than once a year after the child is 27.

Enrollment Requirements
If you are paying all or a portion of premiums for yourself or your dependents then:

- You must enroll within 31 days after completing the eligibility requirement 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.
- You must pay Premiums in the manner elected by the Contractholder and approved by Delta Dental. 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 Dependent Enrollees in the manner elected by the Contractholder and approved by Delta Dental 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.
- If both you and your spouse are eligible persons, one of you may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only 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.

Loss of Eligibility
Your coverage ends on the day you stop working for the Contractholder or immediately when this program ends. Your dependents' coverage ends when your coverage ends or on the date when dependent status is lost.

Continuation of Benefits
Delta Dental will not pay for Benefits for any services received after your coverage ends, but Delta Dental will pay for a Single Procedure incurred when the patient was covered if such procedure is completed within 31 days of the date coverage ends. A dental service is incurred as follows:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

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 an approved leave of absence or as required under the Family & Medical Leave Act of 1993*.

Benefits for you and your Dependent Enrollees will resume as follows:

- if coverage is reactivated in the same Calendar Year, deductibles and maximums will resume as if you were never gone; or
- if coverage is reactivated in a different Calendar Year, new deductibles and maximums will apply.

Coverage will resume the date you return to work, provided you submit to Delta Dental an enrollment card requesting that coverage be reactivated.

*You and your dependents' coverage is not affected if you take a leave of absence allowed under the Family & Medical Leave Act of 1993. 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 does <u>not</u> 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 Calendar 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.

Continuation of Coverage Under COBRA
COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for employees and their Dependent Enrollees who lose employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

DEDUCTIBLE

Your dental plan features a deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The deductible amounts are listed on the Group Highlights page.

Only the Dentist's fees you pay for covered Benefits will count toward the deductible, but you do not have to pay a deductible for Diagnostic and Preventive Benefits.

MAXIMUM AMOUNT

The Maximum Amount payable is shown on the Group Highlights page. There may be maximums on a yearly basis, a per services basis, or a lifetime basis.

BENEFITS, LIMITATIONS & EXCLUSIONS

Delta Dental will pay the Benefits for the types of dental services as described below. Delta Dental will pay Benefits only for covered services. These services must be provided by a Dentist and must be necessary and customary under generally accepted dental practice standards. Delta Dental may use dental consultants to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices. If you receive dental services from a Dentist outside the state of **Texas**, the Dentist will be reimbursed according to Delta Dental's network payment provisions for said state according to the terms of this 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 Dentist 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
Delta Dental's provision of Benefits is limited to the applicable percentage of Dentist's fees shown on the Group Highlights page. You are responsible for paying the remaining applicable percentage of any such fees, known as the "Enrollee Coinsurance". Your group has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between Contractholder and Enrollees.

If the Dentist discounts, waives or rebates any portion of the Enrollee Coinsurance to the Enrollee, Delta Dental will be obligated to provide as Benefits only the applicable percentages of the Dentist's fees reduced by the amount of such fees that is discounted, waived or rebated.

BENEFITS
Delta Dental will pay or otherwise discharge the percentage of Contract Allowance shown on the Group Highlights page for covered services.

Diagnostic and Preventive Benefits:

- Diagnostic: procedures to assist the Dentist in choosing required dental treatment.
- Preventive: prophylaxis (cleaning, topical application of fluoride solutions and space maintainers.
- Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

Basic Benefits:

- Oral Surgery: extractions and other surgical procedures (including pre-and post-operative care).
- General Anesthesia or IV Sedation: when administered by a Dentist for covered oral surgery or selected endodontic and periodontal surgical procedures.
- Endodontics: treatment of the tooth pulp.
- Periodontics: treatment of gums and bones supporting teeth, periodontal cleaning in the presence of inflamed gums.
- Palliative: treatment to relieve pain.
- Restorative: amalgam, synthetic porcelain, posterior resin composites, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- Denture Repairs: repair to partial or complete dentures including rebase procedures and relining.
- Other Basic Services: bruxism appliances, recementation of bridges.

Major Benefits:

- Crowns, Inlays/Onlays and Cast Restorations: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations.
- Prosthodontics: procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges; addition of clasp or tooth to a partial denture; 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 Calendar Year while the Enrollee is covered under this 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. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted.

LIMITATIONS

Limitations on Diagnostic and Preventive Benefits:

- Routine oral examinations and cleanings (excluding periodontal cleanings) are provided no more than twice in any Calendar Year while the patient is an Enrollee under any Delta Dental or dental care program provided by the Contractholder. Note that periodontal cleanings are covered as a Basic Benefit and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional benefits during pregnancy.
- Full-mouth x-rays and panoramic x-rays are limited to once every three (3) years while the person is an Enrollee under any Delta Dental program.
- Bitewing x-rays are provided once in any Calendar Year for you and your spouse and twice in any Calendar Year for your Dependent Child Enrollees.
- Topical application of fluoride solutions is limited to Enrollees under age 19.
- Space maintainers are limited to the initial appliance only and to Enrollees under age 14.
- Sealants are limited as follows:
  (1) to application to permanent molars to age 16 if they are without cavities or restorations on the occlusal surface.
  (2) Sealants do not include repair or replacement of a sealant on any tooth within five (5) years of its application.

Limitations on Basic Benefits:

- Periodontal cleanings are provided no more than twice in any Calendar Year while the patient is an Enrollee under any Delta Dental or dental care program provided by the Contractholder. See note on additional benefits during pregnancy.
- Delta Dental will not pay to replace an amalgam, synthetic porcelain or plastic restorations (fillings) or prefabricated stainless steel restorations within 24 months of treatment if the service is provided by the same Dentist.

- Delta Dental limits payment for stainless steel crowns under this section to services on baby teeth. However, after consultant's review, Delta Dental may allow stainless steel crowns on permanent teeth as a Major Benefit.
- 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.

Limitations on Major Benefits:
- Delta Dental will not pay to replace any crowns, inlays/onlays, or cast restorations which the Enrollee received in the previous five (5) years under any Delta Dental program or any program of the Contractholder.
- Prosthodontic appliances and/or implants that were provided under any Delta Dental program will be replaced only after five (5) years 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. 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. Delta Dental will pay for the removal of an implant once for each tooth during the Enrollee's lifetime.
- Delta Dental limits payment for dentures to a standard partial or denture (coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.

Limitations on All Benefits - Optional 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. For example:
- a crown where a filling would restore the tooth;
- a precision denture/partial where a standard denture/partial could be used; or
- an inlay/onlay instead of an amalgam restoration.

If you receive Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You 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.

EXCLUSIONS
Delta Dental does not pay Benefits for:
- treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, except for services covered by the Medical Assistance Act of 1967, as amended (Article 695j-1, Vernon's Texas Civil Statutes). Delta Dental will reimburse the Texas Department of Human Services for the cost of services paid by the Department under the said Act to the extent such costs are for services which are Benefits under this Contract.

  If the Texas Department of Human Services is paying benefits pursuant to Chapters 31 and 32 of the Human Services Code (financial and medical assistance programs administered pursuant to the Human Services code) and a parent who is covered by the group policy has possession or access to a child pursuant to a court order, or is entitled to access or possession of a child and is required by the court to pay child support, then all benefits paid on behalf of the child or children must be paid to the Texas Department of Human Services.

- cosmetic surgery or dentistry for purely cosmetic reasons.

- 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), unless the service is provided to a newborn or adopted dependent child for treatment of a medically diagnosed congenital defect.

- treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. For example: equilibration, periodontal splinting, occlusal adjustment.

- any Single Procedure started prior to the date the person became covered for such services under this program.

- prescribed drugs, medication, pain killers or experimental procedures.

- charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

- charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Dentist in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.

- extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

- treatment performed by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.

- charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments.

- services or supplies covered by any other health plan of the Contractholder.

- services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Benefits section if applicable.

- services for any disturbances of the temporomandibular (jaw) joints.

COORDINATION OF BENEFITS

Delta Dental matches the Benefits under this program with your Benefits under any other group prepaid program or Benefit plan including another Delta Dental plan. (This does not apply to a blanket school accident policy). Benefits under one of the programs may be reduced so that your combined coverage does not exceed the Dentist's fees for the covered services. If this is the "primary" program, Delta Dental will not reduce Benefits, but if the other program is the primary one, Delta Dental will reduce Benefits otherwise payable under this program. The reduction will be the amount paid for or provided under the terms of the primary program for services covered under the Contract (see Benefits and Limitations).

- How does Delta Dental determine which is the "primary" program?
  (1) If the other Plan is not primarily a dental plan, this Plan is primary.
  (2) If the other Plan is a dental program, the following rules are applied:
      a) the Plan covering the patient as an employee is primary over a Plan covering the patient as a dependent.
      b) the Plan covering the patient 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:
         i) secondary to the Plan covering the insured person as a dependent and
         ii) 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.

d) In the case of a dependent child of divorced parents, the Plan covering the patient 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 patient as a dependent of the parent without legal custody. 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.

   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).

(4) 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.

(5) 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, member or subscriber (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.

(6) If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee longer are determined before those of the Plan which covered that insured person for the shorter term.

AUTOMATED INFORMATION LINE

You may access Delta Dental's automated information line on a regular business day to obtain information on Member Eligibility and Benefits; Group Benefit Information; Claim Status or to speak to a Customer Service Representative for assistance. **AVA (800) 521-2651**

CLAIMS

Claims for Benefits must be filed on a standard Claim Form which you or your Dentist may obtain from:

Delta Dental Insurance Company
P.O. Box #1809
Alpharetta, Georgia 30023
(800) 521-2651
deltadentalins.com

PRE-TREATMENT ESTIMATES

A Dentist may file a Claim Form before treatment, showing the services to be provided to an Enrollee. Delta Dental will predetermine the amount of Benefits payable under the Contract for the listed services. Benefits will be processed according to the terms of the Contract when the treatment is performed. Pre-Treatment Estimates are valid for 60 days, or until an earlier occurrence of any one of the following events:

- the date the Contract terminates;
- the date the patient's coverage ends; or
- the date the DPO Dentist's or Premier Dentist's Agreement with Delta Dental ends.

CLAIMS APPEAL

Delta Dental will notify the Primary Enrollee if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. The Enrollee has 180 days after receiving a notice of denial to appeal it by writing to Delta Dental giving reasons why the denial was wrong. The Enrollee may also ask Delta Dental to examine any additional information he/she includes that may support his/her appeal.

Delta Dental will make a full and fair review within 60 days after Delta Dental receives the request for appeal. Delta Dental may ask for more documents if needed. In no event will the decision take longer than 60 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. The review will be conducted for Delta Dental by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. The identity of such dental consultant is available upon request whether or not the advice was relied upon.

If the Enrollee believes he/she needs further review of said claim, he/she may contact his/her state insurance regulatory agency if applicable or bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if the Contract is subject to ERISA.

PROVISIONS REQUIRED BY LAW

Clinical Examination
Before approving a claim, Delta Dental will be entitled to receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an Enrollee as may be required to administer the claim, or that an Enrollee be examined by a dental consultant retained by Delta Dental, in or near his community or residence. Delta Dental will in every case hold such information and records confidential.

Notice of Claim Forms
Delta Dental will give any Dentist or Enrollee, on request, a standard Claim Form to make claim for Benefits. To make a claim, the form must be completed and signed by the Dentist who performed the services and by the Enrollee (or the parent or guardian if the patient is a minor) and submitted to Delta Dental.

If the form is not furnished by Delta Dental within 15 days after requested by a Dentist or Enrollee, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to Delta Dental, 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.

Written Notice of Claim/Proof of Loss
Delta Dental must be given written proof of loss within 90 days 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 Delta Dental within 6 months of the termination of the Contract.

Time of Payment
Claims payable under this Contract for any loss other than loss for which this Contract provides any periodic payment will be paid no later than 60 days after written proof loss is received. Delta Dental will notify the Primary Enrollee and his/her dentist of any additional information needed to process the claim within this 60 day period. Delta Dental will process the claim within 15 days of receipt of the additional information. If the requested information is not received within 45 days, the claim will be denied. Subject to due written proof of loss, all accrued indemnities for loss for which this Contract provides periodic payment will be paid monthly.

To Whom Benefits are Payable
DPO Dentists and Premier Dentists will be paid directly. Any other payments provided by the Contract will be made to the Primary Enrollee, unless the Enrollee requests when filing a proof of loss claim that the payment be made directly to the Dentist providing the services. All Benefits not paid to the Dentist will be payable to the Enrollee, or to his estate, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to the parent, guardian or other person actually supporting him.

Severability
If any part of this program is found by a court or other authority to be illegal, void or not enforceable, all other portions of this program will remain in full force and effect.

Conformity with State Laws
All legal questions about this program will be governed by the state of Texas where the Contract was entered into and is to be performed. Any part of this program which, on its Effective Date, conflicts with the laws of Texas is hereby amended to conform to the minimum requirements of such laws.

Misstatements on Application; Effect
In the absence of fraud, all statements made by you or your employer 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 your or your employer, a copy of which has been furnished to your employer or the Enrollee.

Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to Delta Dental, Delta Dental would not in good faith have issued the contract at the same premium rate. If any misstatement would materially affect the rates, Delta Dental reserves the right to adjust the premium to reflect your actual circumstances at enrollment.

Misstatement of Age
If the age of the Enrollee has been misstated, all amounts payable under the contract shall be such as the premium paid would have purchased at the correct age.

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.

Not in Lieu of Workers' Compensation
This contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance.

Certificate of Insurance
This certificate is not assignable and the Benefits are not assignable prior to a claim. If any change to this program will materially affect any Benefits described in this certificate, new certificates or riders showing the change will be issued.

Professional Relationship
Applicant and Delta Dental agree to permit and encourage the professional relationship between Dentist and patient to be maintained without interference.

Time Limit On Certain Defenses
After the Contract has been in force for two (2) years from the Effective Date, no statement made by the Contractholder will be used to void the Contract. No statement by you, with respect to an Enrollee's insurability, will be used to reduce or deny a claim or contest the validity of insurance for such Enrollee after that person's coverage has been in effect two (2) years.

Cancellation of Program
- on an anniversary of the Effective Date upon 60 days written notice; or
- if your employer does not pay the monthly premiums upon 31 days written notice; or
- if your employer does not provide a list of who is eligible upon 60 days written notice; or
- if less than the minimum number of Primary enrollees required under the Contract reported eligible for three (3) months or more, upon 15 days written notice.

THIS CERTIFICATE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE DENTAL INSURANCE CONTRACT. THE COMPLETE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

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. Maaaring 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 نُوفّر 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けます。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 بخواهیا 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’į’ yídóołtahígíí nihee hóló. Díí naaltsoos t’áá Diné bizaad k’ehjí ályaago ałdó’ nich’į’ ádoolnį́į́łgo bíighah. T’áá jíík’e shíká i’doolwoł nínízingo kojį’ béésh 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.

AMENDMENT NO: 4

Group No. 05813

IT IS AGREED that the Contract effective April 1, 2009 between **DELTA DENTAL INSURANCE COMPANY** and **CLUBCORP USA, INC.** is hereby **AMENDED** effective April 1, 2022 as follows:

- Item 2.03 under ARTICLE 2, ELIGIBILITY AND ENROLLMENT is **DELETED** and **REPLACED** with the following:

  2.03 **Eligible Employees**
  A full-time employee working 30 hours per week becomes eligible on whichever is later, the Effective Date or on the first day of the month following 30 days of continuous employment.

Except as **AMENDED** all terms and provisions of this Contract shall remain unchanged.

CLUBCORP USA, INC.

_____
Contractholder's Signature

DELTA DENTAL INSURANCE COMPANY



Michael G. Hankinson, Esq., President

SuperiorVision By MetLife

Vision Benefits – MetLife Superior Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. You may enroll yourself and your eligible dependents. Also, you do not have to enroll in medical coverage to elect the vision plan.

To find a network provider, visit **www.metlife.com**, click "Find a Vision Provider," then click "MetLife Vision Superior."

View a full list of covered vision services by clicking **here**.

Plan Highlights	
Network	MetLife Network
Vision Exam – Every 12 months	
In-Network **Out-of-Network**	$15 Copay Ophthalmologist: Up to $42, Optometrist: Up to $37
Lenses – Every 12 months	
Single Lenses **In-Network** **Out-of-Network**	 $15 Copay Up to $26
Bifocal **In-Network** **Out-of-Network**	 $15 Copay Up to $34
Trifocal **In-Network** **Out-of-Network**	 $15 Copay Up to $50
Frames – Every 24 months	
In-Network **Out-of-Network**	$15 Copay, $125 Allowance Up to $50
Contacts – Every 12 months (In lieu of lenses & frames)	
Medically Necessary Contacts **In-Network** **Out-of-Network**	 $0 Up to $210
Elective Contacts **In-Network** **Out-of-Network**	 $120 Allowance Up to $100

The above information is a summary only. Please refer to your Certificate of Coverage for complete details of Plan benefits, limitations and exclusions.

Vision Plan Cost	Bi-Weekly
Employee Only	$2.93
Employee and Spouse	$4.36
Employee and Child(ren)	$4.66
Employee and Family	$7.45

YOUR BENEFIT PLAN

ClubCorp USA, Inc.

All Full-Time Employees

Vision Insurance for You and Your Dependents

Certificate Date: January 1, 2023

Certificate Number 4

ClubCorp USA, Inc.
3030 LBJ Freeway, Suite 600
Dallas, TX 75234

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

ClubCorp USA, Inc.



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a legal contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

Policyholder:	ClubCorp USA, Inc.
Group Policy Number:	119217-1-G
Type of Insurance:	Vision Insurance
MetLife Toll Free Number(s): For Claim Information	FOR VISION CLAIMS: 1-833-EYE-LIFE (1-833-393-5433)

THIS CERTIFICATE ONLY DESCRIBES VISION INSURANCE.

FOR CALIFORNIA RESIDENTS: REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON YOUR EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

For Idaho Residents: TEN DAY RIGHT TO EXAMINE CERTIFICATE: You may return the certificate to Us within 10 days from the date You receive it. If You return it within the 10 day period, the certificate will be considered never to have been issued. We will refund any premium paid after We receive Your notice of cancellation.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

For New Mexico Residents: This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that You have health insurance coverage. If You do not have other health insurance coverage, You may be subject to a federal tax penalty.

For New Hampshire Residents: 30 Day Right to Examine Certificate.

Please read this Certificate. You may return the Certificate to Us within 30 days from the date You receive it. If you return it within the 30 day period, the Certificate will be considered never to have been issued and We will refund any premium paid for insurance under this Certificate.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

NOTICE FOR RESIDENTS OF TEXAS

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Metropolitan Life Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Corporate Consumer Relations Department at 1-800-438-6388

Toll-free: 1-800-438-6388

Email: CAG@versanthealth.com

Mail: Superior Vision
Attention: Complaints and Appeals
P.O. Box 791
Latham, NY 12110

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Metropolitan Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388

Teléfono gratuito: 1-800-438-6388

Correo electrónico: CAG@versanthealth.com

Dirección postal: Superior Vision
Attention: Complaints and Appeals
P.O. Box 791
Latham, NY 12110

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

NOTICE FOR RESIDENTS OF ALASKA, CONNECTICUT, LOUISIANA, MINNESOTA, NEW HAMPSHIRE, NEW MEXICO, UTAH AND WASHINGTON

The Definition Of Child Is Modified For The Coverages Listed Below:

For Alaska Residents (Vision Insurance):

The term also includes newborns.

For Connecticut Residents (Vision Insurance):

The age limit for children will not be less than 26, regardless of the child's marital status, student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

A Child's insurance will not end due to age until the end of the Year in which that Child attains age 26.

For Louisiana Residents (Vision Insurance):

The term also includes Your grandchildren residing with You. The age limit for children and grandchildren will not be less than 21, regardless of the child's or grandchild's student status or full-time employment status. In addition, the age limit for students will not be less than 24. Your natural child, adopted child, stepchild or grandchild under age 21 will not need to be supported by You to qualify as a Child under this insurance.

For Minnesota Residents (Vision Insurance):

The term also includes:

- Your grandchildren who are financially dependent upon You and reside with You continuously from birth;
- children for whom You or Your Spouse is the legally appointed guardian; and
- children for whom You have initiated an application for adoption.

The age limit for children and grandchildren will not be less than 25 regardless of the child's or grandchild's student status or full-time employment status. Your natural child, adopted child stepchild or children for whom You or Your Spouse is the legally appointed guardian under age 25 will not need to be supported by You to qualify as a Child under this insurance.

For New Hampshire Residents (Vision Insurance):

The age limit for children will not be less than 26, regardless of the child's marital status, student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

For New Mexico Residents (Vision Insurance):

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild will not be denied vision insurance coverage under this certificate because:

- that child was born out of wedlock;
- that child is not claimed as Your dependent on Your federal income tax return; or
- that child does not reside with You.

NOTICE FOR RESIDENTS OF ALASKA, CONNECTICUT, LOUISIANA, MINNESOTA, NEW HAMPSHIRE, NEW MEXICO, UTAH AND WASHINGTON (continued)

For Utah Residents (Vision Insurance):

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance. The term includes an unmarried child who is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law and who has been continuously covered under a Vision plan since reaching age 26, with no break in coverage of more than 63 days, and who otherwise qualifies as a Child except for the age limit. Proof of such handicap must be sent to Us within 31 days after:

- the date the Child attains the limiting age in order to continue coverage; or
- You enroll a Child to be covered under this provision;

and at reasonable intervals after such date, but no more often than annually after the two-year period immediately following the date the Child qualifies for coverage under this provision.

For Washington Residents (Vision Insurance):

The age limit for children will not be less than 26, regardless of the child's marital status, student status, or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

NOTICE FOR RESIDENTS OF ALL STATES WHO ARE INSURED FOR VISION INSURANCE

Notice Regarding Your Rights and Responsibilities

Rights:

- We will treat communications, financial records and records pertaining to Your care in accordance with all applicable laws relating to privacy.
- Decisions with respect to vision treatment are the responsibility of You and the Vision Provider. We neither require nor prohibit any specified treatment. However, only certain specified services are covered for benefits. Please see the Vision Insurance sections of this certificate for more details.
- You may request a written response from MetLife to any written concern or complaint.

Responsibilities:

- You are responsible for the prompt payment of any charges for services performed by the Vision Provider not fully covered by your Vision Insurance.
- You should consult with the Vision Provider about treatment options, proposed and potential procedures, anticipated outcomes, potential risks, anticipated benefits and alternatives. You should share with the Vision Provider the most current, complete and accurate information about Your medical and vision history and current conditions and medications.
- You should follow the treatment plans and health care recommendations agreed upon by You and the Vision Provider.

NOTICE FOR RESIDENTS OF ARKANSAS

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
Consumer Services Division
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR METLIFE AT:

SUPERIOR VISION
ATTENTION: COMPLAINTS AND APPEALS
P.O. BOX 791
LATHAM, NY 12110

1-800-438-6388

IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA DEPARTMENT OF INSURANCE DEPARTMENT AT:

DEPARTMENT OF INSURANCE
CONSUMER SERVICES
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013

WEBSITE: http://www.insurance.ca.gov/

1-800-927-4357 (within California)
1-213-897-8921 (outside California)

NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

California law provides that for vision insurance, domestic partners of California's residents must be treated the same as spouses. If the certificate does not already have a definition of domestic partner, then the following definition applies:

> **"Domestic Partner** means each of two people, one of whom is an employee of the Policyholder, a resident of California and who have registered as domestic partners or members of a civil union with the California government or another government recognized by California as having similar requirements."

If the certificate already has a definition of domestic partner, that definition will apply to California residents, as long as it recognizes as a domestic partner any person registered as the employee's domestic partner with the California government or another government recognized by California as having similar requirements.

Wherever the term **"Spouse"** appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Wherever the term step-child appears, it is replaced by step-child or child of Your Domestic Partner.

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

NOTICE FOR RESIDENTS OF IDAHO

If You have a question concerning Your coverage or a claim, first contact the Policyholder. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife, You may write to:

Superior Vision
Attention: Complaints and Appeals
P.O. Box 791
Latham, NY 12110

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company

1-833-EYE-LIFE (1-833-393-5433)

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at www.in.gov/idoi

NOTICE FOR RESIDENTS OF MAINE

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as for nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this certificate to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf , or any covered Dependent may request reinstatement of the certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

NOTICE FOR MASSACHUSETTS RESIDENTS

CONTINUATION OF VISION INSURANCE

1. If Your Vision Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.

2. If Your Vision Insurance ends because:

    - You cease to be in an Eligible Class; or
    - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your Vision Insurance under the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

CONTINUATION OF VISION INSURANCE FOR YOUR FORMER SPOUSE

If the judgment of divorce dissolving Your marriage provides for continuation of insurance for Your former Spouse when You remarry, Vision Insurance for Your former Spouse that would otherwise end may be continued.

To continue Vision insurance under this provision:

1. You must make a written request to the employer to continue such insurance;
2. You must make any required premium to the employer for the cost of such insurance.

The request form will be furnished by the Employer.

Such insurance may be continued from the date Your marriage is dissolved until the earliest of the following:

- the date Your former Spouse remarries;
- the date of expiration of the period of time specified in the divorce judgment during which You are required to provide Vision Insurance for Your former Spouse;
- the date coverage is provided under any other group health plan;
- the date Your former Spouse becomes entitled to Medicare;
- the date Vision Insurance under the policy ends for all active employees, or for the class of active employees to which You belonged before Your employment terminated;
- the date of expiration of the last period for which the required premium payment was made; or
- the date such insurance would otherwise terminate under the policy.

If Your former Spouse is eligible to continue Vision Insurance under this provision and any other provision of this Policy, all such continuation periods will be deemed to run concurrently with each other and shall not be deemed to run consecutively.

NOTICE FOR RESIDENTS OF MISSISSIPPI

CLAIMS FOR VISION INSURANCE

Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-833-EYE-LIFE (1-833-393-5433).

Initial Determination

If Your claim for Vision Insurance benefits is a Clean Claim and it is approved, benefits will be paid within 25 days after We receive Proof in an electronic form of a covered loss, or within 35 days after receipt of Proof in paper form of a covered loss. Proof includes, but is not limited to, information essential for Us to administer coordination of benefits.

"Clean Claim" means a claim that:

- does not require further information, adjustment or alteration by You or the provider of the services in order to process and pay it;
- does not have any defects;
- does not have any impropriety, including any lack of supporting documentation; and
- does not involve a particular circumstance required special treatment that substantially prevents timely payments from being made on the claim.

A Clean Claim does not include a claim submitted by a provider more than 30 days after the date of service, or if the provider does not submit the claim on Your behalf, a claim submitted more than 30 days after the date the provider bills You. Errors, such as system errors, attributable to the insurer, do not change the clean claim status.

If We do not deny payment of such benefits to You by the end of the 25 day period for clean claims submitted in electronic form, or 35 day period for Clean Claims submitted in paper form, and such benefits remain due and payable to You, interest will accrue on the amount of such benefits at the rate of 3 percent per month until such benefits are finally settled. If We do not pay benefits to You when due and payable, You may bring action to recover such benefits, any interest which has accrued with respect to such benefits and any other damages which may be allowed by law. We will pay benefits when We receive satisfactory Proof of Your claim.

If We are unable to pay a claim for Vision Insurance benefits because additional information or documentation is required, or there is a particular circumstance requiring special treatment, within 25 days after the date We receive the claim if it is submitted in electronic form, or within 35 days after the date MetLife receives the claim if it is submitted in paper form, We will send You notice of what supporting documentation or information is needed. Any claim or portion of a claim for Vision Insurance benefits that is resubmitted with all of the supporting documentation requested in Our notice and becomes payable will be paid to You within 20 days after it is received.

NOTICE FOR RESIDENTS OF MISSISSIPPI

Claim Denial Appeals

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

Initial Appeal. All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

Second Level Appeal. If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

Other Remedies. When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

Time of Action. No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy. If it is determined in such action that We acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, You (or the provider, if You assigned the benefits to the provider) shall be entitled to recover any interest which may accrue plus damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

Insurance Fraud: Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

NOTICE FOR NEW HAMPSHIRE RESIDENTS

CONTINUATION OF YOUR VISION INSURANCE

If You are a resident of New Hampshire, Your Vision Insurance may be continued if it ends because Your employment ends unless:

- Your employment ends due to Your gross misconduct;
- this Vision Insurance ends for all employees;
- this Vision Insurance is changed to end Vision Insurance for the class of employees to which You belong;
- You are entitled to enroll in Medicare; or
- Your Vision Insurance ends because You failed to pay the required premium.

The Employer must give You written notice of:

- Your right to continue Your Vision Insurance;
- the amount of premium payment that is required to continue Your Vision Insurance;
- the manner in which You must request to continue Your Vision Insurance and pay premiums; and
- the date by which premium payments will be due.

The premium that You must pay for Your continued Vision Insurance may include:

- any amount that You contributed for Your Vision Insurance before it ended;
- any amount the Employer paid; and
- an administrative charge which will not to exceed two percent of the rest of the premium.

To continue Your Vision Insurance, You must:

- send a written request to continue Your Vision Insurance; and
- pay the first premium within 30 days after the date Your employment ends.

The maximum continuation period will be the longest of:

- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if You become entitled to disability benefits under Social Security within 60 days of the date Your Employment ends; or
- 18 months.

Your continued Vision Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Vision Insurance ends;
- the date this Vision Insurance is changed to end Vision Insurance for the class of employees to which You belong;
- the date You are entitled to enroll for Medicare;
- if You do not pay the required premium to continue Your Vision Insurance; or
- the date You become eligible for coverage under any other group Vision coverage.

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF YOUR DEPENDENT'S VISION INSURANCE

If You are a resident of New Hampshire, Your Vision Insurance for Your Dependents may be continued if it ends because Your employment ends, Your marriage ends in divorce or separation, or You die, unless:

- Your employment ends due to Your gross misconduct;
- this Vision Insurance ends for all Dependents;
- this Vision Insurance is changed, for the class of employees to which You belong, to end Vision Insurance for Dependents;
- the Dependent is entitled to enroll in Medicare; or
- Your Vision Insurance for Your Dependents ends because You fail to pay a required premium.

If Vision Insurance for Your Dependents ends because Your marriage ends in divorce or separation, the party responsible under the divorce decree or separation agreement for payment of premium for continued Vision Insurance must notify the employer, in writing, within 30 days of the date of the divorce decree or separation agreement that the divorce or separation has occurred. If You and Your divorced or separated Spouse share responsibility for payment of the premium for continued Vision Insurance, both You and Your divorced or separated Spouse must provide the notification.

The Employer must give You, or Your former Spouse if You have died or Your marriage has ended, written notice of:

- Your right to continue Your Vision Insurance for Your Dependents;
- the amount of premium payment that is required to continue Your Vision Insurance for Your Dependents;
- the manner in which You or Your former Spouse must request to continue Your Vision Insurance for Your Dependents and pay premiums; and
- the date by which premium payments will be due.

The premium that You or Your former Spouse must pay for continued Vision Insurance for Your Dependents may include:

- any amount that You contributed for Your Vision Insurance before it ended; and
- any amount the Employer paid.

To continue Vision Insurance for Your Dependents, You or Your former Spouse must:

- send a written request to continue Vision Insurance for Your Dependents; and
- must pay the first premium within 30 days of the date Vision Insurance for Your Dependents ends.

If You, and Your former Spouse, if applicable, fail to provide any required notification, or fail to request to continue Vision Insurance for Your Dependents and pay the first premium within the time limits stated in this section, Your right to continue Vision Insurance for Your Dependents will end.

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF YOUR DEPENDENT'S VISION INSURANCE (Continued)

The maximum continuation period will be the longest of the following that applies:

- 36 months if Vision Insurance for Your Dependents ends because Your marriage ends in divorce or separation, except that with respect to a Spouse who is age 55 or older when your marriage ends in divorce or separation the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group plan;
- 36 months if Vision Insurance for Your Dependents ends because You die, except that with respect to a Spouse who is age 55 or older when You die, the maximum continuation period will end when Your surviving Spouse becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months if Vision Insurance for Your Dependents ends because You become entitled to benefits under Title XVIII of Social Security, except that with respect to a Spouse who is age 55 or older when You become entitled to benefits under Title XVIII of Social Security, the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months if You become entitled to benefits under Title XVIII of Social Security while You are already receiving continued benefits under this section, except that with respect to a Spouse who is age 55 or older when You first become entitled to continue Your Vision Insurance the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months with respect to a Dependent Child if Vision Insurance ends because the Child ceases to be a Dependent Child;
- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if Vision Insurance for Your Dependents ends because Your employment ends, and within 60 days of the date Your employment ends you become entitled to disability benefits under Social Security; or
- 18 months if Vision Insurance for Your Dependents ends because Your employment ends.

A Dependent's continued Vision Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Vision Insurance ends;
- the date this Vision Insurance is changed to end Vision Insurance for Dependents for the class of employees to which You belong;
- the date the Dependent becomes entitled to enroll for Medicare;
- if You do not pay a required premium to continue Vision Insurance for Your Dependents; or
- the date the Dependent becomes eligible for coverage under any other group vision coverage.

NOTICE FOR RESIDENTS OF NEW MEXICO

Consumer Complaint Notice

If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: https://www.osi.state.nm.us/ConsumerAssistance/index.aspx.

NOTICE FOR RESIDENTS OF PENNSYLVANIA

Vision Insurance for a Dependent Child may be continued past the age limit if that Child is a full-time student and insurance ends due to the Child being ordered to active duty (other than active duty for training) for 30 or more consecutive days as a member of the Pennsylvania National Guard or a Reserve Component of the Armed Forces of the United States.

Insurance will continue if such Child:

- re-enrolls as a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
- re-enrolls for the first term or semester, beginning 60 or more days from the child's release from active duty;
- continues to qualify as a Child, except for the age limit; and
- submits the required Proof of the child's active duty in the National Guard or a Reserve Component of the United States Armed Forces.

Subject to the Date Insurance For Your Dependents Ends subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, this continuation will continue until the earliest of the date:

- the insurance has been continued for a period of time equal to the duration of the child's service on active duty; or
- the child is no longer a full-time student.

NOTICE FOR RESIDENTS OF ALL STATES

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

NOTICE FOR RESIDENTS OF TEXAS

If You are a resident of Texas and live in a county where there is no In-Network Vision Provider and travel distance to an In-Network Dentist is more than 90 minutes travel time and 75 miles away, We will pay benefits for Covered Services provided by an Out-of-Network Vision Provider as if the service was provided by an In-Network Vision Provider. In order to ensure that the benefits are paid accordingly, We must be notified prior to receiving services from an Out-of-Network Vision Provider. Please call Us at 1-833-EYE-LIFE (1-833-393-5433) for assistance.

If You or a Dependent receive emergency or urgent vision care from an Out-of-Network Vision Provider, We will pay benefits for those Covered Services provided by an Out-of-Network Vision Provider as if the services were provided by an In-Network Vision Provider.

NOTICE FOR RESIDENTS OF UTAH

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 in disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 lA, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

NOTICE FOR RESIDENTS OF THE STATE OF VERMONT

Vermont law provides that the following apply to Your certificate:

Domestic Partner means each of two people, one of whom is an Employee of the Policyholder, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "**Spouse**" appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

NOTICE TO RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

Superior Vision
Attention: Complaints and Appeals
P.O. Box 791
Latham, NY 12110

To phone in a claim related question, You may call Claims Customer Service at:
1-833-EYE-LIFE (1-833-393-5433)

If You have any questions regarding an appeal or grievance concerning the vision services that You have been provided that have not been satisfactorily addressed by this Vision Insurance, You may contact the Virginia Office of the Managed Care Ombudsman for assistance.

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
1-804-371-9691 - phone
1-877-310-6560 - toll-free
1-804-371-9944 - fax
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

Or:

Office of Licensure and Certification
Division of Acute Care Services
Virginia Department of Health
9960 Mayland Drive
Suite 401
Henrico, Virginia 23233-1463
Phone number: 1-800-955-1819/ local: 804-367-2106
Fax: (804) 527-4503
MCHIP@vdh.virginia.gov

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

NOTICE TO RESIDENTS OF VIRGINIA (continued)

VISION INSURANCE: PROCEDURES FOR VISION CLAIMS

Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-833-EYE-LIFE (1-833-393-5433).

Claim Denial Appeals

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

Initial Appeal. All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

Second Level Appeal. If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

Other Remedies. When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

Time of Action. No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy.

Insurance Fraud: Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

NOTICE FOR RESIDENTS OF THE STATE OF WASHINGTON

Washington law provides that the following apply to Your certificate:

Wherever the term "**Spouse"** appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Domestic Partner means each of two people, one of whom is an Employee of the Policyholder, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If You are having problems with Your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve Your problem.

Superior Vision
Attention: Complaints and Appeals
P.O. Box 791
Latham, NY 12110
1-833-EYE-LIFE (1-833-393-5433)

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.

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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents are only covered for insurance:

- for which You become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

In addition, You are eligible for Dependent Insurance only while You have Dependents who qualify.

BENEFIT **BENEFIT AMOUNTS AND HIGHLIGHTS**

Provider Network: **Superior Vision Network**

Vision Insurance For You and Your Dependents

	Exam	Lenses	Frame	Contacts
Service Interval	12 months	12 months	24 months	12 months

	In-Network	Out-of-Network
Exam Co-Payment *Co-Payment shall not apply to Retinal Imaging*	$15	$15
Materials Co-Payment *Co-Payment shall not apply to Contact Lenses*	$15	$10

	In-Network Coverage (Using an In-Network Vision Provider)	Out-of-Network Coverage (Using an Out-of-Network Vision Provider)	
EYE EXAMINATION (one per frequency)	Covered in full after any applicable Co-Payment Comprehensive examination of visual functions and prescription of corrective eyewear.	Allowance after any applicable Co-Payment Up to $42 for Ophthalmologists Up to $37 for Optometrists Comprehensive examination of visual functions and prescription of corrective eyewear.	
RETINAL IMAGING	Covered in full with a Co-Payment not to exceed $39. Coverage for retinal imaging is an enhancement to eye examination. Retinal imaging is not available at all provider locations – contact your In-Network Vision Provider to see if this technology (or equipment or service) is available.	Applied to the allowance for the eye examination	
STANDARD CORRECTIVE LENSES	Covered in full after any applicable Co-Payment Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)	Single Vision	$26 allowance
		Lined Bifocal	$34 allowance
		Lined Trifocal	$50 allowance
		Lenticular	$80 allowance

SCHEDULE OF BENEFITS (continued)

	In-Network Coverage (Using an In-Network Vision Provider)		Out-of-Network Coverage (Using an Out-of-Network Vision Provider)
STANDARD LENS OPTIONS	Standard Polycarbonate (child up to age 18)	Covered in full	Applied to the allowance for the applicable corrective lens
These lens options are available with a "not to exceed" pricing/maximum member out of pocket amount.[1]	Progressive – Standard	$55	$50 allowance
	Progressive – Premium	$110	
	Progressive – Ultra	$150	
	Progressive – Ultimate	$225	
	Ultra Violet Coating	$12	Applied to the allowance for the applicable corrective lens
	Standard Polycarbonate (adult)	$40	
	Scratch Resistant Coating	Tier 1 - $15 Tier 2 - $30	
	Anti-Reflective Coating	Tier 1 - $50 Tier 2 - $70 Tier 3 - $85 Tier 4 - $120	
	Tints/Dyes – Solid	Covered in full	
	Tints/Dyes – Gradient	Covered in full	
	Photochromic	Covered in full	
	Blue Light Filtering	$15	
	Digital Single Vision	$30	
	Polarized	$75	
	High Index (1.67/1.74)	$80/$120	
FRAMES	Covered up to a $125 allowance after any applicable Co-Payment		$50 allowance after any applicable Co-Payment
CONTACT LENSES			
FITTING AND EVALUATION	**Standard Fit:** Covered in full after $25 Co-Payment **Specialty Fit:** $50 allowance after $25 Co-Payment		Applied to the allowance for contact lenses
ELECTIVE	$120 allowance Contact lenses are provided in place of lens and frame benefits available herein.		$100 allowance Contact lenses are provided in place of lens and frame benefits available herein.

SCHEDULE OF BENEFITS (continued)

	In-Network Coverage (Using an In-Network Vision Provider)	Out-of-Network Coverage (Using an Out-of-Network Vision Provider)
NECESSARY	Covered in full Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Vision Provider. Contact lenses are provided in place of lens and frame benefits available herein.	$210 allowance Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Out-of-Network Vision Provider. Contact lenses are provided in place of lens and frame benefits available herein.

[1] Not all providers participate in vision program discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if the discount and member out-of-pocket features are offered at that location. Discounts and member out-of-pocket are not insurance and subject to change without notice.

Value-Added Features Available At In-Network Vision Providers (These features are not insurance.)	
ADDITIONAL SAVINGS ON GLASSES AND SUNGLASSES	20% savings on additional pairs of prescription glasses and nonprescription sunglasses, including lens enhancements. [2]
ADDITIONAL SAVINGS ON LENS ENHANCEMENTS	Average 20-25% savings on all lens enhancements not otherwise covered under the Superior Vision by MetLife vision benefit program. [2]
ADDITIONAL SAVINGS ON FRAMES	20% off any amount over your frames allowance. [2]
SAVINGS ON ADDITIONAL EXAMS	30% savings on additional exams. [2]
ADDITIONAL SAVINGS ON CONTACTS	10% off any amount over your disposable contact lens allowance or 20% off any amount over your conventional contact lens allowance.[2] 10% - 20% discount on additional contacts. [2]

[2] These features may not be available in all states and with all In-Network Vision Providers. Please check with Your In-Network Vision Provider.

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:

- the Policyholder's place of business;
- an alternate place approved by the Policyholder; or
- a place to which the Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Policyholder approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Anisometropia means a condition of unequal refractive state of the two eyes, one eye requiring a different lens correction than the other.

Child means the following: (for residents of Alaska, Connecticut, Louisiana, Minnesota, New Hampshire, New Mexico, Utah and Washington, the Child Definition is modified as explained in the notice pages of this certificate - please consult the Notice)

Your natural or adopted child; Your stepchild; Your foster child; or a child who resides with and is fully supported by You; and who, in each case, is under age 26.

The term also includes Your child or grandchild who is under age 26, and who was able to be claimed by You as a Dependent for Federal Income Tax purposes at the time You applied for Vision Insurance.

A child will be considered Your adopted child during the period You are party to a suit in which You are seeking the adoption of the child.

If You provide Us notice, a Child also includes a child for whom You must provide Vision Insurance due to a Qualified Medical Child Support Order as defined in the United States Employee Retirement Income Security Act of 1974 as amended.

The term includes an Employee's Child who is incapable of self-sustaining employment because of a mental or physical disability as defined by applicable law, and has been so disabled continuously since a date before the Child reached the limiting age and who otherwise qualifies as a Child except for the age limit.

The term does not include any person who is insured under the Group Policy as an employee.

Contributory Insurance means insurance for which the Policyholder requires You to pay any part of the premium.

Contributory Insurance includes: Vision Insurance for You and Vision Insurance for Your Dependents.

Co-Payment or Co-Pay means a fixed dollar amount for which We are not responsible, as shown in the Schedule of Benefits. You must pay Your Co-Payment at the time services are rendered or materials ordered.

Covered Person(s) means an Employee and/or a Dependent covered under this Certificate.

DEFINITIONS (continued)

Covered Services and Materials mean a vision service or materials used to treat Your or Your Dependent's vision condition which is:

- prescribed or performed by a Vision Provider while such person is insured for Vision Insurance;
- Necessary to treat the condition; and
- described in the SCHEDULE OF BENEFITS or VISION INSURANCE: DESCRIPTION OF COVERED SERVICES AND MATERIALS sections of this certificate.

Dependent(s) means Your Spouse and/or Child.

Full-Time means Active Work of at least 30 hours per week on the Policyholder's regular work schedule for the eligible class of employees to which You belong.

In-Network Vision Provider means an optometrist, therapeutic optometrist, ophthalmologist, or optician licensed and otherwise qualified to practice vision care and/or provide vision care materials who is contracted to provide Plan Benefits to Covered Persons of MetLife and accepts reimbursement at the negotiated rate.

Keratoconus means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area.

Maximum Benefit Allowance means the maximum amount We will allow for Covered Services and Materials provided by a Vision Provider.

Necessary means Covered Services and Materials that are necessary and meet with professionally recognized standards of practice. The fact that a Vision Provider may prescribe, order, recommend or approve a service or material does not, in itself, make it medically necessary, or make it a Covered Service and Material even though it is listed in the Group Policy or the Benefit Schedule as Covered Service and Material.

Out-of-Network Vision Provider/Non-Network Vision Provider means any optometrist, therapeutic optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted to provide vision care services and/or vision care materials to Covered Persons of MetLife.

Plan or Plan Benefits means the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Certificate.

Progressive Lens means a multifocal lens that makes the transition from distance to near vision by a gradual, progressive addition of power. The result is a lens with a seamless appearance.

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant’s right to receive payment.

Proof must be provided at the claimant’s expense.

DEFINITIONS (continued)

Service Interval or Frequency means a period of consecutive months, as shown in the SCHEDULE OF BENEFITS, in which You or Your Dependent may receive Covered Services and Materials. This period starts on Your or Your Dependent's effective date of coverage. A subsequent service interval starts after vision services or materials are received. Once Covered Services and Materials are received during any service interval, additional services are not covered during the same service interval and are subject to an additional charge.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Spouse means Your lawful spouse.

For the purposes of determining who may become covered for insurance, the term does not include any person who:

- is on active duty in the military of any country or international authority. However, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.

Vision Provider means an eye care professional who is an optometrist, therapeutic optometrist, ophthalmologist, or registered dispensing optician, who:

- Is licensed as such by the proper authorities in the jurisdiction where such services are performed;
- Is acting within the scope of such license.

We, Us and **Our** mean MetLife.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Year or **Yearly**, for Vision Insurance, means the 12 month period that begins January 1.

You and **Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Full-Time employees of the Policyholder.

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

You will be eligible for the insurance described in this certificate on the later of:

1. January 1, 2023; and

2. the first day of the calendar month following the date You complete the Waiting Period of 30 Days.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

ENROLLMENT PROCESS FOR VISION INSURANCE

If You are eligible for insurance, You may enroll for such insurance by completing the required form in Writing. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

The Vision Insurance has a regular enrollment period established by the Policyholder. Subject to the rules of the Group Policy, You may enroll for Vision Insurance only when You are first eligible, during an annual enrollment period or if You have a Qualifying Event. You should contact the Policyholder for more information regarding the flexible benefits plan.

DATE YOUR INSURANCE TAKES EFFECT

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, the insurance will take effect on the day You resume Active Work.

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for insurance until the next enrollment period for Vision Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

Enrollment During An Annual Enrollment Period

During any annual enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible. The changes to Your insurance made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the date You resume Active Work.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

Enrollment Due to a Qualifying Event

You may enroll for insurance for which You are eligible between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for, or changes to Your insurance made as a result of a Qualifying Event, will take effect on the date of the Qualifying Event, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Qualifying Event includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- a change in Your or Your dependent's residence, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- a significant curtailment in Your current option, a significant improvement in an option for which You are not enrolled, a significant increase or decrease in cost for one or more of the options under the Policyholder's plan or a new benefit option under the Policyholder's plan; or
- Your taking leave under the United States Family and Medical Leave Act; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage; or
- You previously did not enroll for Vision Insurance for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
    1. loss of eligibility for the other group coverage;
    2. termination of employer contributions for the other group coverage;
    3. COBRA Continuation of the other group coverage was exhausted; or
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
    - You to provide health coverage for Your child or dependent foster child; or
    - Your spouse, former spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage; or
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines); or
- You or Your dependent lose entitlement to Medicare or Medicaid eligibility; or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the date You cease to be in an eligible class;
4. the end of the period for which the last premium has been paid for You;
5. the date Your employment ends, Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
6. the last day of the calendar month in which You retire in accordance with the Policyholder's retirement plan.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All Full-Time employees of the Policyholder.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

You may only become eligible for the Dependent insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

You will be eligible for Dependent insurance described in this certificate on the latest of:

1. January 1, 2023; and
2. the first day of the calendar month following the date You complete the Waiting Period of 30 days; and
3. the date You obtain a Dependent.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

No person may be insured as a Dependent of more than one employee.

ENROLLMENT PROCESS FOR DEPENDENT VISION INSURANCE

If You are eligible for Dependent Insurance, You may enroll for such insurance by completing the required form in Writing for each Dependent to be insured. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

In order to enroll for Vision Insurance for Your Dependents, You must either (a) already be enrolled for Vision Insurance for You or (b) enroll at the same time for Vision Insurance for You.

The Vision Insurance has a regular enrollment period established by the Policyholder. Subject to the rules of the Group Policy, You may enroll for Dependent Vision Insurance only when You are first eligible, during an enrollment period or if You have a Qualifying Event. You should contact the Policyholder for more information regarding the flexible benefits plan.

DATE VISION INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for Dependent Insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, the insurance will take effect on the day You resume Active Work.

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for Dependent Insurance until the next enrollment period for Vision Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Enrollment During An Annual Enrollment Period

During any enrollment period as determined by the Policyholder, You may enroll for Dependent Insurance for which You are eligible. The changes to Your Dependent Insurance made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the date You resume Active Work.

Enrollment Due to a Qualifying Event

You may enroll for Dependent Insurance for which You are eligible between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the date of the Qualifying Event, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Qualifying Event includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- a change in Your or Your dependent's residence, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- a significant curtailment in Your current option, a significant improvement in an option for which You are not enrolled, a significant increase or decrease in cost for one or more of the options under the ’s plan or a new benefit option under the ’s plan; or
- Your taking leave under the United States Family and Medical Leave Act; or
- Your dependent's ceasing to qualify as a dependent under this or under other group coverage; or
- You previously did not enroll for Vision for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
    1. loss of eligibility for the other group coverage;
    2. termination of employer contributions for the other group coverage;
    3. COBRA Continuation of the other group coverage was exhausted; or
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
    - You to provide health coverage for Your child or dependent foster child; or
    - Your spouse, former spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage; or
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines); or

- You or Your dependent lose entitlement to Medicare or Medicaid eligibility; or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

Once You have enrolled one Child for Dependent Insurance, each succeeding Child will automatically be insured for such insurance on the date the Child qualifies as a Dependent.

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

A Dependent's insurance will end on the earliest of:

1. the date You die;
2. the date Vision Insurance for You ends;
3. the date the Group Policy ends;
4. the date You cease to be in an eligible class;
5. the date insurance for Your Dependents ends under the Group Policy;
6. the date insurance for Your Dependents ends for Your class;
7. the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT;
8. the end of the period for which the last premium has been paid;
9. the last day of the calendar month the person ceases to be a Dependent;
10. the last day of the calendar month in which a Dependent Child reaches the limiting age;
11. the last day of the calendar month in which You retire in accordance with the Policyholder’s retirement plan.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Child attains the age limit and at reasonable intervals after such date, but not more frequently than once a year after the two-year period following the child's attainment of the limiting age.

Subject to the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, insurance will continue while such Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Child, except for the age limit.

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Policyholder for information regarding such legally mandated leave of absence laws.

COBRA CONTINUATION FOR VISION INSURANCE

If Vision Insurance for You or a Dependent ends, You or Your Dependent may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). Please refer to the COBRA section of Your summary plan description or contact the Policyholder for information regarding continuation of insurance under COBRA.

AT THE POLICYHOLDER'S OPTION

The Policyholder has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below. If Your insurance is continued, insurance for Your Dependents may also be continued.

Insurance will continue for the following periods:

1. if You cease Active Work due to any other Policyholder approved leave of absence, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
2. if You cease Active Work due to layoff, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
3. if You cease Active Work due to injury or sickness, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
4. if You cease Active Work due to strike, for a period in accordance with the Policyholder's general practice for an employee in Your job class.

The Policyholder's general practice for employees in a job class determines which employees with the above types of absences are to be considered as still insured and for how long among persons in like situations.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

If Your insurance ends, Your Dependents' insurance will also end in accordance with the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS.

VISION INSURANCE

Benefits are available for Covered Services and Materials provided by either In-Network Vision Providers or Out-of-Network Vision Providers. However, You may be able to reduce Your out-of-pocket costs by using In-Network Vision Providers because Out-of-Network Vision Providers have not entered into an agreement to limit their charges. You are always free to receive services from any Vision Provider. You do not need any authorization from Us before seeing a Vision Provider.

In-Network Vision Providers have agreed to provide Covered Services and Materials as listed in the SCHEDULE OF BENEFITS.

If You or a Dependent incur a charge for Covered Services and Materials from an Out-of-Network Vision Provider, Proof of such service must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the insurance in effect on the date that service was completed.

The benefits available under this Vision Insurance are set forth on the SCHEDULE OF BENEFITS. In addition to the Co-Payment, if applicable, You may be responsible for:

- the cost of any services or materials that are not Covered Services and Materials; and
- the cost of any service or material that is in excess of the Maximum Benefit Allowance listed on the SCHEDULE OF BENEFITS.

We do not provide vision services. Whether or not benefits are available for a particular service does not mean You should or should not receive the service. You and Your Vision Provider have the right and are responsible at all times for choosing the course of treatment and services to be performed.

When requesting Covered Services and Materials from an In-Network Vision Provider, We recommend that You confirm that the Vision Provider is currently an In-Network Vision Provider at the time that the Covered Services and Materials are provided.

You can obtain a customized listing of MetLife's In-Network Vision Providers either by calling 1-833-EYE-LIFE (1-833-393-5433) or by visiting Our website at www.metlife.com/mybenefits.

PLAN BENEFITS

We will pay benefits for charges incurred by You or a Dependent for Covered Services and Materials as shown in the SCHEDULE OF BENEFITS, subject to the conditions set forth in this certificate.

If You receive Covered Services and Materials from an In-Network Vision Provider, We will pay the provider directly for all covered benefits.

If You or Your Dependent receive Covered Services and Materials from an Out-of-Network Vision Provider, and You assign payment of Vision Insurance benefits to Your or Your Dependent's Vision Provider, We will pay benefits directly to the Vision Provider. Otherwise, We will pay Vision Insurance benefits to You.

In-Network

If Covered Services and Materials are provided by an In-Network Vision Provider, We will base the benefit on the Plan Benefits listed on the SCHEDULE OF BENEFITS.

If an In-Network Vision Provider provides Covered Services and Materials, You will be responsible for paying:

- the Co-Payment, if applicable; and
- the cost of any service or material that is in excess of the Plan Benefits listed on the SCHEDULE OF BENEFITS.

VISION INSURANCE (continued)

Out-of-Network

If Covered Services and Materials are provided by an Out-of-Network Vision Provider, We will base the benefit on the Plan Benefits listed on the SCHEDULE OF BENEFITS, subject to the Maximum Benefit Allowance.

Out-of-Network Vision Providers may charge You more than the Maximum Benefit Allowance. If an Out-of-Network Vision Provider provides Covered Services and Materials, You will be responsible for paying any amount in excess of the Maximum Benefit Allowance charged by the Out-of-Network Vision Provider.

Necessary Contact Lenses

Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by a Covered Person's In-Network Vision Provider. Generally, coverage will be authorized for the following reasons:

- Aphakia—379.31 or 743.35.
- Nystagmus—379.50 through 379.56, 386.11, 386.12 or 386.2.
- Keratoconus—371.60, 371.61, 371.62, 743.41, or 743.42.
- Corneal transplant—V42.5.
- Corneal dystrophies—371.50 through 371.58.
- Anisometropia greater than or equal to 2.00 diopters difference in any meridian based on the spectacle prescription.
- High ametropia greater than or equal to ±10.00 diopters in either eye in any meridian based on the spectacle prescription.
- Irregular astigmatism—367.22.

The codes listed above are from the International Classification of Diseases, Ninth Revision, Clinical Modification and are used to describe diseases, injuries, symptoms and conditions. If You have questions about the diagnoses listed above or the codes included with the diagnoses, please contact Your Vision Provider.

VISION INSURANCE: DESCRIPTION OF COVERED SERVICES AND MATERIALS

Subject to the Service Intervals and Plan Benefits indicated in the SCHEDULE OF BENEFITS, the following will be Covered Services and Materials:

1. One complete visual examination, if indicated as a Covered Service on the SCHEDULE OF BENEFITS. Dilation is included as a Covered Service when provided by an In-Network Vision Provider.
2. Standard corrective lenses. We will cover a pair of standard single vision, lined bifocal, lined trifocal or lenticular lenses that are necessary to correct vision. Standard corrective lenses are as follows:
    - eyesizes up to and including 60mm;
    - multi-focal lenses in all segment widths;
    - prism and slab off;
    - base curves (regardless of curve);
    - lenses with the combined power in any meridian is +/- .50 diopters or greater in at least one eye; and
    - plastic or glass lenses.
3. The following lens options described in the SCHEDULE OF BENEFITS: tint (solid and gradient), standard plastic scratch coating, standard polycarbonate (if you are less than 18 years of age), standard anti-reflective coating, plastic photochromic, blue light filtering, digital single vision, polarized, high index (1.67/1.74).
4. Contact lenses.
    - A standard fitting and 1 follow-up visit by a Vision Provider.
    - The following contact lenses options, as described in the SCHEDULE OF BENEFITS: conventional, disposable, and Necessary.
5. Necessary low vision aids.
6. We do not cover costs above the Maximum Benefit Allowance shown in the SCHEDULE OF BENEFITS for frames. If frames are selected that are more expensive than that amount, You will be charged the difference between the Maximum Benefit Allowance and the Vision Provider's charge for the more expensive frame.
7. Necessary contact lenses in lieu of all benefits for vision materials.

VISION INSURANCE: EXCLUSIONS

We will not pay Vision Insurance benefits for charges incurred for:

1. Services and/or materials not specifically included in the SCHEDULE OF BENEFITS as covered Plan Benefits.
2. Any portion of a charge in excess of the Maximum Benefit Allowance or reimbursement indicated in the SCHEDULE OF BENEFITS.
3. Plano lenses (lenses with refractive correction of less than ± .50 diopter).
4. Two pairs of glasses instead of bifocals.
5. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost, stolen or damaged, except at the normal intervals when Plan Benefits are otherwise available.
6. Orthoptics or vision training and any associated supplemental testing.
7. Medical or surgical treatment of the eye.
8. Prescription or non-prescription medications.
9. Contact lens insurance policies and service agreements.
10. Refitting of contact lenses after the initial (90-day) fitting period.
11. Contact lens modification, polishing and cleaning.
12. Any eye examination or any corrective eyewear required as a condition of employment.
13. Services or supplies received by You or Your Dependent before the Vision Insurance starts for that person.
14. Missed appointments.
15. Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
16. Local, state and/or federal taxes, except where MetLife is required by law to pay.
17. Services:
    - for which the employer of the person receiving such services is required to pay by law; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
18. Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
19. Services and materials obtained while outside the United States, except for emergency vision care.
20. Services, procedures, or materials for which a charge would not have been made in the absence of insurance.

VISION INSURANCE: COORDINATION OF BENEFITS

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the primary Plan. The primary Plan must pay benefits in accord with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the primary Plan is the secondary Plan. The secondary Plan may reduce the benefits it pays so that payments from all Plans equal 100 percent of the total Allowable Expense.

DEFINITIONS

(a) A "**Plan**" is any of the following that provides benefits or services for vision care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts

(1) Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit Plans and exclusive provider benefit Plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of vision care; vision care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the vision benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state Plan under Medicaid; a governmental Plan that, by law, provides benefits that are in excess of those of any private insurance Plan; or other nongovernmental Plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage under (a)(1) or (a)(2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

(b) "**This Plan**" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as vision benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a primary Plan or secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits equal 100 percent of the total Allowable Expense.

(c) "**Allowable expense**" is a vision care expense, including deductibles, coinsurance, and copayments, that 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. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

(1) If a person is covered by two or more Plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(2) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(3) If a person is covered by one Plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another Plan that provides its benefits or services based on negotiated fees, the primary Plan's payment arrangement must be the Allowable Expense for all Plans. However, if the health care provider or physician has contracted with the secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the health care provider's or physician's contract permits, the negotiated fee or payment must be the Allowable Expense used by the secondary Plan to determine its benefits.

(4) The amount of any benefit reduction by the primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, prior authorization of admissions, and preferred provider arrangements.

(d) "**Allowed amount**" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred provider. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(e) "**Closed Panel Plan**" is a Plan that provides vision care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.

(f) "**Custodial Parent**" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

ORDER OF BENEFIT DETERMINATION RULES

(a) The primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

(b) Except as provided in (c), a Plan that does not contain a COB provision that is consistent with this policy is always primary unless the provisions of both Plans state that the complying Plan is primary.

(c) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

(d) A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

(e) If the primary Plan is a Closed Panel Plan and the secondary Plan is not, the secondary Plan must pay or provide benefits as if it were the primary Plan when a covered person uses a noncontracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary Plan.

(f) When multiple contracts providing coordinated coverage are treated as a single Plan under this subchapter, this section applies only to the Plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the Plan, the carrier designated as primary within the Plan must be responsible for the Plan's compliance with this subchapter.

(g) If a person is covered by more than one secondary Plan, the order of benefit determination rules of this subchapter decide the order in which secondary Plans' benefits are determined in relation to each other. Each secondary Plan must take into consideration the benefits of the primary Plan or Plans and the benefits of any other Plan that, under the rules of this contract, has its benefits determined before those of that secondary Plan.

(h) Each Plan determines its order of benefits using the first of the following rules that apply.

(1) **Nondependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary Plan, and the Plan that covers the person as a dependent is the secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as other than a dependent, then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary Plan and the other Plan is the primary Plan. An example includes a retired employee.

(2) **Dependent Child Covered Under More Than One Plan**. Unless there is a court order stating otherwise, Plans covering a Dependent Child must determine the order of benefits using the following rules that apply.

(A) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:

(i) The Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan; or

(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the primary Plan.

(B) For a Dependent Child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

(i) if a court order states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the Plan is given notice of the court decree.

(ii) if a court order states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of (h) (2)(A) must determine the order of benefits.

(iv) if there is no court order allocating responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the Child are as follows:

(I) the Plan covering the custodial parent;

(II) the Plan covering the spouse of the custodial parent;

(III) the Plan covering the noncustodial parent; then

(IV) the Plan covering the spouse of the noncustodial parent.

(C) For a Dependent Child covered under more than one Plan of individuals who are not the parents of the Child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the Child.

(D) For a Dependent Child who has coverage under either or both parents' Plans and has his or her own coverage as a dependent under a spouse's Plan, (h)(5) applies.

(E) In the event the Dependent Child's coverage under the spouse's Plan began on the same date as the Dependent Child's coverage under either or both parents' Plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent Child's parent(s) and the dependent's spouse.

(3) Active, Retired, or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan that covers that same person as a retired or laid-off employee is the secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the Plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary Plan, and the COBRA, state, or other federal continuation coverage is the secondary Plan. 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 does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary Plan, and the Plan that has covered the person the shorter period is the secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

(a) When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the primary Plan. The secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary Plan, the total benefits paid or provided by all Plans for the claim equal 100 percent of the total Allowable Expense for that claim. In addition, the secondary Plan must credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(b) If a covered person is enrolled in two or more closed panel Plans and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel Plan, COB must not apply between that Plan and other closed panel Plans.

COMPLIANCE WITH FEDERAL AND STATE LAWS CONCERNING CONFIDENTIAL INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. Each person claiming benefits under This Plan must give Us any facts it needs to apply those rules and determine benefits.

VISION INSURANCE: COORDINATION OF BENEFITS (continued)

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

VISION INSURANCE: FILING A CLAIM

CLAIMS FOR VISION INSURANCE

If you select an In Network Vision Provider, You do not need to file a claim.

If you select an Out-of-Network Vision Provider, You may provide full payment to the Out-of-Network Vision Provider at the time of service and submit the invoice including an itemized statement of charges with Your claim form, or You may be able to assign the claim to the Out-of-Network Vision Provider. If the Out-of-Network Vision Provider accepts the assignment, the provider will submit the claim on your behalf. You will be responsible for any charges not covered by the Plan.

Out of network claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-833-EYE-LIFE (1-833-393-5433). Vision claim forms can also be downloaded from www.metlife.com/mybenefits. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

When We receive the claim form and Proof, Your claim will be paid subject to the terms and provisions of this certificate and the Group Policy.

CLAIMS FOR VISION INSURANCE BENEFITS

When a claimant files a claim for Vision Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 180 days from the date of service.

Claim and Proof may be given to Us by following the steps set forth below:

Step 1
A claimant can request a claim form by downloading it from www.metlife.com/mybenefits.

Step 2
Complete the claim form as instructed and return it with the invoice.

Step 3
The claimant must give Us Proof not later than 180 days from the date of service.

VISION INSURANCE: PROCEDURES FOR VISION CLAIMS

Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-833-EYE-LIFE (1-833-393-5433).

Claim Denial Appeals
If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

Initial Appeal. All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

Second Level Appeal. If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

Other Remedies. When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

Time of Action. No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy.

Insurance Fraud: Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, may be guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

Upon receipt of a Covered Service, You may assign Vision Insurance benefits to the Vision Provider providing such service.

Vision Insurance: Who We Will Pay

If You assign payment of Vision Insurance benefits to Your or Your Dependent's Vision Provider, We will pay benefits directly to the Vision Provider. Otherwise, We will pay Vision Insurance benefits to You.

Entire Contract

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty.

Evidence of insurability will not be required nor will any statement made by You, which relates to insurability, be used:

1. to contest the validity of the insurance benefits; or
2. to reduce the insurance benefits.

Conformity with Law

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

THE PRECEDING PAGE IS THE END OF THE CERTIFICATE.
THE FOLLOWING IS ADDITIONAL INFORMATION.

MetLife

Delaware American Life Insurance Company
MetLife Health Plans, Inc.
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.
Metropolitan General Insurance Company
Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

SECTION 2: Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

SECTION 3: Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life insurers, a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

SECTION 4: How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB, Inc. ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's

file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

SECTION 6: Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

SECTION 7: HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

SECTION 8: Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. We will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

SECTION 9: Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.

HIPAA Notice of Privacy Practices for Protected 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.

Dear MetLife Customer:

This is your Health Information Privacy Notice from Metropolitan Life Insurance Company or a member of the MetLife, Inc. family of companies, which includes SafeGuard Health Plans, Inc., SafeHealth Life Insurance Company, and Delaware American Life Insurance Company (collectively, "**MetLife**"). **Please read it carefully.** You have received this notice because of your Dental, Vision, Long-Term Care, Cancer and Specified Disease Expense Insurance, or Health coverage with us (your "**Coverage**"). MetLife strongly believes in protecting the confidentiality and security of information we collect about you. This notice refers to MetLife by using the terms "us," "we," or "our."

This notice describes how we protect the personal health information we have about you which relates to your MetLife Coverage ("**Protected Health Information**" or "**PHI**"), and how we may use and disclose this information. PHI includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This notice also describes your rights with respect to the PHI and how you can exercise those rights.

We are required to provide this notice to you by the Health Insurance Portability and Accountability Act ("**HIPAA**"). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please see the privacy notices contained at our website,**www.metlife.com**. You may submit questions to us there or you may write to us directly at MetLife, Americas – U.S. HIPAA Privacy Office, P.O. Box 902, New York, NY 10159-0902.

NOTICE SUMMARY

The following is a brief summary of the topics covered in this HIPAA notice. Please refer to the full notice below for details.

As allowed by law, we may **use** and **disclose** PHI to:

- make, receive, or collect payments;
- conduct health care operations;
- administer benefits by sharing PHI with affiliates and Business Associates;
- assist plan sponsors in administering their plans; and
- inform persons who may be involved in or paying for another's health care.

In addition, we may use or disclose PHI:

- where required by law or for public health activities;
- to avert a serious threat to health or safety;
- for health-related benefits or services;
- for law enforcement or specific government functions;
- when requested as part of a regulatory or legal proceeding; and
- to provide information about deceased persons to coroners, medical examiners, or funeral directors.

You have the right to:

- receive a copy of this notice;
- inspect and copy your PHI, or receive a copy of your PHI;
- amend your PHI if you believe the information is incorrect;
- obtain a list of disclosures we made about you (except for treatment, payment, or health care operations);

- ask us to restrict the information we share for treatment, payment, or health care operations;
- request that we communicate with you in a confidential manner; and
- complain to us or the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

We are required by law to:

- maintain the privacy of PHI;
- provide this notice of our legal duties and privacy practices with respect to PHI;
- notify affected individuals following a breach of unsecured PHI; and
- follow the terms of this notice.

NOTICE DETAILS

We protect your PHI from inappropriate use or disclosure. Our employees, and those of companies that help us service your MetLife Coverage, are required to comply with our requirements that protect the confidentiality of PHI. They may look at your PHI only when there is an appropriate reason to do so, such as to administer our products or services.

Except in the case of Long-Term Care Coverage, we will **not use or disclose** PHI that is genetic information for underwriting purposes. For example, we will not use information from a genetic test (such as DNA or RNA analysis) of an individual or an individual's family members to determine eligibility, premiums or contribution amounts under your Coverage.

We will **not sell or disclose** your PHI to any other company for their use in marketing their products to you. However, as described below, we will use and disclose PHI about you for business purposes relating to your Coverage.

The main reasons we may **use** and **disclose** your PHI are to evaluate and process any requests for coverage and claims for benefits you may make or in connection with other health-related benefits or services that may be of interest to you. The following describe these and other uses and disclosures.

- **For Payment:** We may use and disclose PHI to pay benefits under your Coverage. For example, we may review PHI contained in claims to reimburse providers for services rendered. We may also disclose PHI to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose PHI to a health plan or an administrator of an employee welfare benefit plan for various payment-related functions, such as eligibility determination, audit and review, or to assist you with your inquiries or disputes.

- For Health Care Operations: We may also use and disclose PHI for our insurance operations. These purposes include evaluating a request for our products or services, administering those products or services, and processing transactions requested by you.

- To Affiliates and Business Associates: We may disclose PHI to Affiliates and to business associates outside of the MetLife family of companies if they need to receive PHI to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of PHI. Examples of business associates are: billing companies, data processing companies, companies that provide general administrative services, health Information organizations e-prescribing gateways, or personal health record vendors that provide services to covered entities. PHI may be disclosed to reinsurers for underwriting, audit or claim review reasons. PHI may also be disclosed as part of a potential merger or acquisition involving our business in order that the parties to the transaction may make an informed business decision.

- To Plan Sponsors: We may disclose summary health information such as claims history or claims expenses to a plan sponsor to enable it to obtain premium bids from health plans, or to modify, amend or terminate a group health plan. We may also disclose PHI to a plan sponsor to help administer its plan if the plan sponsor agrees to restrict its use and disclosure of PHI in accordance with federal law.

- To Individuals Involved in Your Care: We may disclose your PHI to a family member or other individual who is involved in your health care or payment of your health care. For example, we may disclose PHI to a covered family member whom you have authorized to contact us regarding payment of a claim.

- Where Required by Law or for Public Health Activities: We disclose PHI when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing PHI to a governmental agency or regulator with health care oversight responsibilities.

- To Avert a Serious Threat to Health or Safety: We may disclose PHI to avert a serious threat to someone's health or safety. We may also disclose PHI to federal, state or local agencies engaged in disaster relief, as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

- For Health-Related Benefits or Services: We may use your PHI to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about health-related products or services that may be of

interest to you. However, we will not send marketing communications to you in exchange for financial remuneration from a third party without your authorization.

- **For Law Enforcement or Specific Government Functions:** We may disclose PHI in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose PHI about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **When Requested as Part of a Regulatory or Legal Proceeding:** If you or your estate are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the PHI requested. We may disclose PHI to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

- **PHI about Deceased Individuals :** We may release PHI to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death. In addition, we may disclose a deceased's person's PHI to a family member or individual involved in the care or payment for care of the deceased person unless doing so is inconsistent with any prior expressed preference of the deceased person which is known to us.

- **Other Uses of PHI:** Other uses and disclosures of PHI not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose PHI about you, you or your legally authorized representative may revoke that authorization in writing at any time, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your Coverage. You should understand that we will not be able to take back any disclosures we have already made with authorization.

Your Rights Regarding Protected Health Information That We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your PHI. Should you have questions about or wish to exercise a specific right, please contact us in writing at the applicable Contact Address listed on the last page.

- **Right to Inspect and Copy Your PHI:** In most cases, you have the right to inspect and obtain a copy of the PHI that we maintain about you. If we maintain the requested PHI electronically, you may ask us to provide you with the PHI in electronic format, if readily producible; or, if not, in a readable electronic form and format agreed to by you and us. To receive a copy of your PHI, you may be charged a fee for the costs of copying, mailing, electronic media, or other supplies associated with your request. You may also direct us to send the PHI you have requested to another person designated by you, so long as your request is in writing and clearly identifies the designated individual. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI collected by us in connection with, or in reasonable anticipation of, any claim or legal proceeding. In very limited circumstances, we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

- **Right to Amend Your PHI:** If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must specify the reason for your request. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend PHI that:

  - is accurate and complete;
  - was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment;
  - is not part of the PHI kept by or for us; or
  - is not part of the PHI which you would be permitted to inspect and copy.

- **Right to a List of Disclosures:** You have the right to request a list of the disclosures we have made of your PHI. This list will not include disclosures made for treatment, payment, health care operations, purposes of national security, to law enforcement, to corrections personnel, pursuant to your authorization, or directly to you. To request this list, you must submit your request in writing. Your request must state the time period for which you want to receive a list of disclosures. You may only request an accounting of disclosures for a period of time less than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any cost.

- **Right to Request Restrictions:** You have the Right to request a restriction or limitation on PHI we

Use or disclose about you for treatment, payment, or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, **we are not required to agree to it.** If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.

- **Right to Request Confidential Communications :** You have the right to request that we communicate with you about PHI in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Contact Addresses:** If you have any questions about a specific individual right or you want to exercise one of your individual rights, please submit your request in writing to the address below which applies to your Coverage:

MetLife or SafeGuard Dental & Vision
P.O. Box 14587
Lexington, KY 40512-4587

MetLife LTC Privacy Coordinator
1300 Hall Boulevard, 3rd Floor
Bloomfield, CT 06002

Delaware American Life Insurance Company
MetLife Worldwide Benefits
P.O. Box 1449
Wilmington, DE 19899-1449

Cancer and Specified Disease Expense Insurance
c/o Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, TX 78716

- **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact MetLife, Americas – U.S. HIPAA Privacy Office, P.O. Box 902, New York, NY 10159-0902. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have questions as to how to file a complaint, please contact us at telephone number (212) 578-0299 or at HIPAAprivacyAmericasUS@metlife.com.

ADDITIONAL INFORMATION

Changes to This Notice: We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for PHI we already have about you, as well as any PHI we receive in the future. The effective date of this notice and any revised or changed notice may be found on the last page, on the bottom right-hand corner of the notice. You will receive a copy of any revised notice from MetLife by mail or by e-mail, if e-mail delivery is offered by MetLife and you agree to such delivery.

Further Information: You may have additional rights under other applicable laws. For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please e-mail us at HIPAAprivacyAmericasUS@metlife.com or call us at telephone number (212) 578-0299, or write us at:

MetLife, Americas
U.S. HIPAA Privacy Office
P.O. Box 902
New York, NY 10159-0902

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Effective Date: 10252022

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THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE CLUBCORP USA, INC. VISION INSURANCE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

ERISA INFORMATION

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

ClubCorp USA, Inc.
3030 LBJ Freeway, Suite 600
Dallas, TX 75234
972-888-7488

EMPLOYER IDENTIFICATION NUMBER: 75-2114856

PLAN NUMBER	COVERAGE	PLAN NAME
501	All Coverages	ClubCorp Health Benefits Plan, a Health and Welfare Benefit Plan

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the rights to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event Your insurance ends in accordance with the DATE YOUR INSURANCE ENDS and DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsections of Your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife certificate.

CONTRIBUTIONS TO PREMIUM

If you enroll for Vision Insurance coverage, you are required to make contributions to premiums.

Premium rates are set by MetLife.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 1st and ending on the following December 31st.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified Medical Child Support Orders (QMCSO).

CLAIMS INFORMATION

Vision Benefits Claims

Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-833-EYE-LIFE (1-833-393-5433).

Claim Denial Appeals
If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

Initial Appeal. All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

Second Level Appeal. If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

Other Remedies. When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

Time of Action. No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy.

Insurance Fraud: Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO COBRA CONTINUATION COVERAGE

COBRA is a federal law that requires most group health plans to give their employees and their dependents the opportunity to continue coverage when coverage is terminated due to certain specific events. If your employment terminates for any reason other than your gross misconduct, or if your hours worked are reduced so that your coverage terminates, you and your covered dependents may be able to continue coverage under This Plan for a period of up to 18 months. If it is determined under the terms of the Social Security Act that you or your covered dependent is disabled within the first 60 days of COBRA coverage, you and your covered dependents may be able to continue your vision coverage under This Plan for an additional 11 months after the expiration of the 18 month period. In addition, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be able to continue coverage under This Plan for up to 36 months. Also, your covered children may be able to continue coverage under This Plan for up to 36 months after they no longer qualify as covered dependents under the terms of This Plan. Group health plans for employers with fewer than 20 employees, church plans, and plans established and maintained by the federal government are not subject to COBRA continuation requirements.

During the continuation period, a child of yours that is (1) born; (2) adopted by you; or (3) placed with you for adoption, will be treated as if the child were a covered dependent at the time coverage was lost due to an event described above.

This continuation will terminate on the earliest of:

a. the end of the 18, 29 or 36 month continuation period, as the case may be;

b. the date of expiration of the last period for which the required payment was made;

c. the date, after you or your covered dependent elects to continue coverage, that you or your covered dependent first becomes covered under another group health plan as long as the new plan does not contain any exclusion or limitation with respect to your or your covered dependent’s preexisting condition;

d. the date your employer ceases to provide any group health plan for its employees.

Notice will be given when you or your covered dependent becomes entitled to continue coverage under This Plan. You or your covered dependent will then have 60 days to elect to continue coverage. If you or your covered dependent do not notify your Employer within the 60-day election period, you will lose the option to elect continuation coverage.

Each person who is eligible for COBRA coverage is entitled to make a separate election of COBRA coverage. Thus, a covered spouse (as defined by federal law) or dependent child (or parent on their behalf) is entitled to elect COBRA coverage even if the covered Employee does not make that election. However, covered Employees may elect COBRA coverage on behalf of their covered dependents. Any person who elects to continue coverage under This Plan must pay the full cost of that coverage (including both the share you now pay and the share your Employer now pays), plus any additional amounts permitted by law. Your payments for continued coverage must be made on the first day of each month in advance.

If you do not elect COBRA coverage, your vision coverage will end. However, if you initially waive COBRA continuation coverage before the end of the 60-day election period, you may change your election by sending the completed election form to the Plan Administrator and postmarking it no later than the last day of the 60-day election period.

Qualifying Event Due To Bankruptcy Of Employer

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under This Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's covered spouse and covered dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under This Plan.

If You Elect COBRA

If you choose COBRA coverage and pay the required premiums, you are entitled to coverage which, as of the time coverage is being provided, is identical to the coverage provided by the Employer to similarly situated active Employees, spouses or dependent children. This means that if the coverage for similarly situated Employees, spouses or dependent children changes, coverage will change for those who elected COBRA coverage.

Duration Of COBRA Coverage

The law requires that you be given the opportunity to maintain COBRA coverage for 36 months from the date coverage ends as a result of the qualifying event unless you lost coverage because of the covered Employee's termination of employment or reduction in hours. In that case, the required COBRA coverage period is 18 months from the date you lose coverage as a result of the termination of employment or reduction in hours. However, the 18-month coverage period may be extended under the following circumstances:

Disability. If any person entitled to COBRA coverage (the covered Employee, covered spouse or covered dependent child) is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage period and the disability lasts at least until the end of the 18 month period of continuation coverage, then all such persons entitled to elect COBRA coverage may be able to continue coverage for up to 29 months, rather than 18 months.

In order to be eligible for the additional 11 months of COBRA coverage, the covered Employee, covered spouse or covered dependent child must notify the Employer's COBRA Administrator within 60 days of the **latest** of: (1) the Social Security Administration's determination of disability; (2) the date of the qualifying event; (3) the date on which the covered Employee's coverage initially was or will be lost; or (4) the date a person entitled to COBRA coverage is informed of this obligation by being provided the initial COBRA notice for the applicable group health plan. Written notice to the COBRA Administrator must be received before the end of the initial 18-month coverage period. A copy of the Social Security Administration's determination must be provided to the COBRA Administrator. **If these procedures are not followed, there will be no disability extension of COBRA.**

During the additional 11 months of coverage, your cost for that coverage will be approximately 50% higher than it was during the preceding 18 months.

The additional 11 months of coverage provided on account of a disability will end as of the earlier of:

- The first day of the month beginning more than 30 days after a final determination by the Social Security Administration that the disability no longer exists; or

- The last day of the 29th month of total coverage.

A person entitled to COBRA coverage must notify the COBRA Administrator within 30 days if the Social Security Administration determines that the disabled person is no longer disabled. This Plan reserves the right to retroactively cancel COBRA coverage, and will require reimbursement of all benefits paid for claims incurred after coverage terminates.

Subsequent Qualifying Events. If, during the 18-month period of COBRA coverage (or within the 29-month maximum coverage period in the case of a disability extension), the covered Employee and the spouse divorce, the covered Employee dies, the covered Employee becomes entitled to Medicare, or a dependent ceases to be an eligible dependent under the terms of This Plan, then the covered spouse and/or covered dependent child(ren) (as applicable) may be able to extend COBRA coverage for up to 36 months from the date of the termination of employment or reduction in hours.

A person entitled to COBRA coverage must notify the Employer's COBRA Administrator of the subsequent event no later than 60 days after its occurrence. If such notification is not given, the covered spouse and/or covered dependent child will not be entitled to the additional COBRA coverage.

Premiums For COBRA Coverage

A person entitled to COBRA coverage is entirely responsible for paying the premiums for COBRA coverage. The required payment for each continuation coverage period for each option will be described in the notice that is sent when an individual experiences a qualifying event.

Initial Premium Payment

If continuation of coverage is elected, payment for continuation coverage must be made no later than 45 days after the date of such election. (This is the date the election notice is post-marked, if mailed.) If the first payment for continuation coverage is not made in full by the 45th day after the date of election, continuation coverage under This Plan will end. A person entitled to COBRA coverage is responsible for making sure that the amount of the first payment is correct.

After the first payment for continuation coverage, the amount due for each coverage period for each qualified beneficiary will be provided when coverage is elected.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations,all Plan documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Vision Plan Insurance

Continue vision insurance for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

FUTURE OF THE PLAN

It is hoped that This Plan will be continued indefinitely, but ClubCorp USA, Inc. reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of ClubCorp USA, Inc. shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.

Uniformed Services Employment And Reemployment Rights Act

This section describes the right that you may have to continue coverage for yourself and your covered dependents under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation of Group Vision Insurance:

If you take a leave from employment for "service in the uniformed services," as that term is defined in USERRA, and as a consequence your vision insurance coverage under your employer's group vision insurance policy ends, you may elect to continue vision insurance for yourself and your covered dependents, for a limited period of time, as described below.

The law requires that your employer notify you of your rights, benefits and obligations under USERRA including instructions on how to elect to continue insurance, the amount and procedure for payment of premium. If permitted by USERRA, your employer may require that you elect to continue coverage within a period of time specified by your employer.

You may be responsible for payment of the required premium to continue insurance. If your leave from employment for service in the uniformed services lasts less than 31 days, your required premium will be no more than the amount you were required to pay for vision insurance before the leave began; for a leave lasting 31 or more days, you may be required to pay up to 102% of the total vision insurance premium, including any amount that your employer was paying before the leave began.

Your and your covered dependents' insurance that is continued pursuant to USERRA will end on the earliest of the following:

- the end of 24 consecutive months from the date your leave from employment for service in the uniformed services begins; or
- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

You and your covered dependent may become entitled to continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") while you have vision insurance coverage under your employer's group vision insurance policy pursuant to USERRA. Contact your employer for more information.

MetLife

Voluntary Short-Term Disability – MetLife Plan

Disability insurance replaces a portion of your income when you are unable to work due to a qualified illness or non-work-related injury, such as the birth of a new child. Invited provides you with the opportunity to elect Short-Term Disability (STD) through MetLife.

Eligible Hourly Employees working in clubs may participate in the Voluntary STD Plan (except for Employees working in clubs located in HI, NJ, NY or RI due to state-mandated disability plans already available to you).

Short-Term Disability Benefits at a Glance	
Definition of Disability	Prevented from performing the material and substantial duties of your regular occupation
Elimination Period	14 Days
Weekly Benefit	$100, $200, $300, $400 or $500, not greater than 60% of your average weekly salary
Maximum Weekly Benefit	$500 per week
Benefit Duration	13 Weeks
Pre-Existing Condition Limitation	6/12

The above information is a summary only. Please refer to your Certificate of Coverage for complete details of Plan benefits, limitations and exclusions.

Short-Term Disability Cost	
Employee age as of January 1, 2024	Monthly Rate per $10
Under age 25	$0.75
25-29	$0.68
30-34	$0.70
35-39	$0.62
40-44	$0.68
45-49	$0.77
50-54	$0.95
55-59	$1.11
60-64	$1.29
65+	$1.42

Calculate Your Short-Term Disability Rate:

Example:

A 30-year-old employee selects $300 in coverage

$300 / $10 = $30.00
$30 x $0.70 = $21.00

$21.00 x 12 ÷ 26 = **$9.69 per paycheck**

Pre-Existing Conditions

A pre-existing condition is an injury or illness for which you have received advice or treatment from a doctor within 6 months prior to the effective date or your insurance plan.

Company-Sponsored Short-Term Disability Eligibility

Home Office & Salaried Employees in clubs receive company-paid STD benefits at 66.67% of salary for up to 12 weeks with a cap of $1,500 per week, following a 14-day elimination period.

Hourly Employees: View the Short-Term Disability Insurance Certificate, click **here**.

Salaried Employees: View the Short-Term Disability Insurance Certificate, click **here**.

YOUR BENEFIT PLAN

ClubCorp USA, Inc.

All Full-Time Employees

Disability Income Insurance: Short Term Benefits

Certificate Date: January 1, 2023

Certificate Number 6

ClubCorp USA, Inc.
5221 North O'Conner Blvd. Suite 300
Irving, TX 75039

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

ClubCorp USA, Inc.



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

Policyholder:	ClubCorp USA, Inc.
Group Policy Number:	119217-1-G
Type of Insurance:	Disability Income Insurance: Short Term Benefits
MetLife Toll Free Number(s): For Claim Information	FOR DISABILITY INCOME CLAIMS: 1-877-463-8467

THIS CERTIFICATE ONLY DESCRIBES DISABILITY INSURANCE.

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

For Idaho Residents: TEN DAY RIGHT TO EXAMINE CERTIFICATE: You may return the certificate to Us within 10 days from the date You receive it. If You return it within the 10 day period, the certificate will be considered never to have been issued. We will refund any premium paid after We receive Your notice of cancellation.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

For New Hampshire Residents: 30 Day Right to Examine Certificate.
Please read this Certificate. You may return the Certificate to Us within 30 days from the date You receive it. If you return it within the 30 day period, the Certificate will be considered never to have been issued and We will refund any premium paid for insurance under this Certificate.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

NOTICE FOR RESIDENTS OF TEXAS

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Metropolitan Life Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Corporate Consumer Relations Department at 1-800-438-6388

Toll-free: 1-800-438-6388

Email: Johnstown_Complaint_Referrals@metlife.com

Mail: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Metropolitan Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388

Teléfono gratuito: 1-800-438-6388

Correo electrónico: Johnstown_Complaint_Referrals@metlife.com

Dirección postal: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

NOTICE FOR RESIDENTS OF ALL STATES

WORKERS' COMPENSATION
This certificate does not replace or affect any requirement for coverage by workers' compensation insurance.

MANDATORY DISABILITY INCOME BENEFIT LAWS
For Residents of California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico
This certificate does not affect any requirement for any government mandated temporary disability income benefits law.

NOTICE FOR RESIDENTS OF ARKANSAS

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
Consumer Services Division
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR METLIFE AT:

METROPOLITAN LIFE INSURANCE COMPANY
ATTN: CONSUMER RELATIONS DEPARTMENT
500 SCHOOLHOUSE ROAD
JOHNSTOWN, PA 15904

1-800-438-6388

IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA DEPARTMENT OF INSURANCE DEPARTMENT AT:

DEPARTMENT OF INSURANCE
CONSUMER SERVICES
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013

WEBSITE: http://www.insurance.ca.gov/

1-800-927-4357 (within California)
1-213-897-8921 (outside California)

NOTICE FOR RESIDENTS OF CONNECTICUT

MANDATORY REHABILITATION

This certificate contains a mandatory rehabilitation provision, which may require you to participate in vocational training or physical therapy when appropriate.

NOTICE FOR PERSONS WORKING IN DISTRICT OF COLUMBIA (DC)

IMPORTANT NOTICE

The laws of the District of Columbia (DC) prohibit insurers from offsetting or reducing benefits under a short-term disability income insurance policy based on estimated or actual benefits received under the Universal Paid Leave Amendment Act of 2016 (UPL).

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

NOTICE FOR RESIDENTS OF IDAHO

If You have a question concerning Your coverage or a claim, first contact the Policyholder. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife, You may write to:

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company

1-800-438-6388

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at www.in.gov/idoi

NOTICE FOR RESIDENTS OF MAINE

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as for nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this certificate to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, You or any person authorized to act on Your behalf may request reinstatement of the certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

NOTICE FOR MASSACHUSETTS RESIDENTS

CONTINUATION OF DISABILITY INCOME INSURANCE

1. If Your Disability Income Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.

2. If Your Disability Income Insurance ends because:

    - You cease to be in an Eligible Class; or
    - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your Disability Income Insurance under the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

NOTICE FOR RESIDENTS OF MISSISSIPPI

FILING A DISABILITY INCOME INSURANCE CLAIM

The Policyholder should have a supply of claim forms. Obtain a claim form from the Policyholder and fill it out carefully. Return the completed claim form with the required Proof to the Policyholder.

If You are unable to report for Active Work due to a Sickness or accidental injury, and You think that You may be Disabled, You should contact MetLife or Your benefits representative to initiate a claim. We recommend that You do so no later than:

- 14 days with respect to Disability Income Insurance: Short Term Benefits; and
- 12 weeks, with respect to Disability Income Insurance: Long Term Benefits

after the first day You are unable to report for Active Work so that Your claim can be processed in a timely manner.

When a claimant files an initial claim for Disability Income Insurance benefits described in this certificate, the following should be sent to Us:

- notice of claim within 30 days of the date of loss; and
- the required Proof within 90 days after the end of the Elimination Period.

Notice of claim and Proof for Disability Income Insurance may also be given to Us by following the steps set forth below:

Step 1
A claimant may give Us notice by calling Us at the toll-free number shown in the Certificate Face Page within 30 days of the date of a loss.

Step 2
We will send a claim form to the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of giving Us notice of claim.

Step 3
When the claimant receives the claim form the claimant should fill it out as instructed and return it with the required Proof described in the claim form. If the claimant does not receive a claim form within 15 days after giving Us notice of claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

Step 4
The claimant must give Us Proof not later than 90 days after the end of the Elimination Period.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice or Proof are given as soon as is reasonably possible; and, in no event, except in the absence of legal capacity, later than 1 year after the date Proof is otherwise required.

Subject to due Written Proof of loss, all accrued benefits for loss for which this certificate provides periodic payment will be paid as follows:

- Weekly, with respect to Disability Income Insurance: Short Term Benefits;
- Monthly, with respect to Disability Income Insurance: Long Term Benefits.

Any balance remaining unpaid upon the termination of liability will be paid within thirty (30) days after receipt of due Written Proof.

Any benefit due and not paid within 30 days of our receipt of Proof will accrue interest at the rate of three percent (3%) per month on the amount due, until the claim is finally settled or adjudicated.

NOTICE FOR RESIDENTS OF MISSISSIPPI (continued)

Subject to the Time Limit on Legal Actions provision, if We do not pay benefits when due and payable You may bring an action to recover such benefits, any interest which has accrued with respect to such benefits, and any other damages which may be allowed by law. If it is determined in such action that We acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, You or the health care provider shall be entitled to recover damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

Items to be Submitted for a Disability Income Insurance Claim

When submitting Proof on an initial or continuing claim for Disability Income insurance, the following items may be required:

- documentation which must include, but is not limited to, the following information:

    1. the date Your Disability started;
    2. the cause of Your Disability;
    3. the prognosis of Your Disability;
    4. the continuity of Your Disability; and

- Your application for:

    - Other Benefit Sources;
    - Federal Social Security disability benefits; and
    - Workers compensation benefits or benefits under a similar law.

- Written authorization for Us to obtain and release medical, employment and financial information and any other items We may reasonably require to document Your Disability or to determine Your receipt of or eligibility for Other Benefit Sources;

- any and all medical information, including but not limited to:

    1. x-ray films; and
    2. photocopies of medical records, including:

        a) histories,
        b) physical, mental or diagnostic examinations; and
        c) treatment notes; and

- the names and addresses of all:

    1. physicians and medical practitioners who have provided You with diagnosis, treatment or consultation;
    2. hospitals or other medical facilities which have provided You with diagnosis, treatment or consultation;
    3. pharmacies which have filled Your prescriptions within the past three years; and

- additional proof elements as required and described within the additional plan provisions for which you are filing a claim for benefits.

Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

NOTICE FOR RESIDENTS OF ALL STATES

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

NOTICE FOR RESIDENTS OF UTAH

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 in disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 lA, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

NOTICE FOR RESIDENTS OF THE STATE OF VERMONT

Vermont law provides that the following apply to Your certificate:

Domestic Partner means each of two people, one of whom is an Employee of the Policyholder, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "**Spouse**" appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

NOTICE FOR RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife
200 Park Avenue
New York, New York 10166
Attn: Corporate Consumer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:
1-800-275-4638

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance
Life and Health Division
P.O. Box 1157
Richmond, VA 23218-1157
1-804-371-9691 - phone
1-877-310-6560 - toll-free
1-804-371-9944 - fax
www.scc.virginia.gov - web address
BureauOfInsurance@scc.virginia.gov - email

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

NOTICE FOR RESIDENTS OF THE STATE OF WASHINGTON

Washington law provides that the following apply to Your certificate:

Wherever the term "**Spouse"** appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Domestic Partner means each of two people, one of whom is an Employee of the Policyholder, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If You are having problems with Your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve Your problem.

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, New York 10166
1-800-438-6388

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.

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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You will only be insured for the benefits:

- for which You become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS
Disability Income Insurance For You: Short Term Benefits	
Weekly Benefit…….	66.67% of the first $1,500 of Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section
Maximum Weekly Benefit……..	$1,000
Minimum Weekly Benefit……	10% of the Weekly Benefit before reductions for Other Income Benefits or $25, whichever is greater. The minimum weekly benefit is subject to the overpayments and rehabilitation incentive subsections of this Certificate
Elimination Period……	**For Injury** • 14 days of Disability. **For Sickness** • 14 days of Disability.
Maximum Benefit Period……	11 weeks
Rehabilitation Incentives……	Yes

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:

- the Policyholder's place of business;
- an alternate place approved by the Policyholder; or
- a place to which the Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Policyholder approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Appropriate Care and Treatment means medical care and treatment that is:

- given by a Physician whose medical training and clinical specialty are appropriate for treating Your Disability;
- consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;
- consistent with a Physician's diagnosis of Your Disability; and
- intended to maximize Your medical and functional improvement.

Beneficiary means the person(s) to whom We will pay insurance as determined in accordance with the GENERAL PROVISIONS section.

Disabled or **Disability** means that, due to Sickness or as a direct result of accidental injury:

- You are receiving Appropriate Care and Treatment and complying with the requirements of such treatment; and
- You are unable to earn more than 80% of Your Predisability Earnings at Your Own Occupation for any employer; and
- You are unable to perform each of the material duties of Your Own Occupation for any employer.

For purposes of determining whether a Disability is the direct result of an accidental injury, the Disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes.

If Your occupation requires a license, the fact that You lose Your license for any reason will not, in itself, constitute Disability.

Elimination Period means the period of Your Disability during which We do not pay benefits. The Elimination Period begins on the day You become Disabled and continues for the period shown in the SCHEDULE OF BENEFITS.

Full-Time means Active Work of at least 30 hours per week on the Policyholder's regular work schedule for the eligible class of employees to which You belong.

Noncontributory Insurance means insurance for which the Policyholder does not require You to pay any part of the premium.

Own Occupation means the occupation You routinely perform that provides the primary source of Your earned income. In determining your Own Occupation, We will look at Your occupation as it is normally performed instead of how it is performed for any specific employer or in any specific location.

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. Such person must also be certified and/or registered if required by such jurisdiction.

The term does not include:

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse's:
  - parents;
  - children (natural, step or adopted);
  - siblings;
  - grandparents; or
  - grandchildren.

Policyholder's Retirement Plan means a plan which:

- provides retirement benefits to employees; and
- is funded in whole or in part by Policyholder contributions.

The term does not include:

- profit sharing plans;
- thrift or savings plans;
- non-qualified plans of deferred compensation;
- plans under IRC Section 401(k) or 457;
- individual retirement accounts (IRA);
- tax sheltered annuities (TSA) under IRC Section 403(b);
- stock ownership plans; or
- Keogh (HR-10) plans.

Predisability Earnings means:

- **for commission employees,** gross salary or wages You were earning from the Policyholder based on the most recent W-2, or if service of less than one year, the average paid for the period worked prior to Your last day of Active Work before Your Disability began, subject to any increase or decrease in insurance as described in the ELIGIBILITY PROVISIONS: INSURANCE FOR YOU, Increase in Insurance and Decrease in Insurance provisions. We calculate this amount on a weekly basis.
- **for all other employees,** gross salary or wages You were earning from the Policyholder based on Your average monthly wages from the prior October 1 through September 30, subject to any increase or decrease in insurance as described in the ELIGIBILITY PROVISIONS: INSURANCE FOR YOU, Increase in Insurance and Decrease in Insurance provisions. We calculate this amount on a weekly basis

The term includes:

- commissions You earned averaged over the 12 month period from October 1 thru September 30 before Disability began, or over the period of Your employment, if less; and
- contributions You were making through a salary reduction agreement with the Policyholder to any of the following:

DEFINITIONS (continued)

- an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
- an executive non-qualified deferred compensation arrangement; and
- Your fringe benefits under an IRC Section 125 plan.

The term does not include:

- awards and bonuses;
- overtime pay;
- the grant, award, sale, conversion and/or exercise of shares of stock or stock options;
- the Policyholder's contributions on Your behalf to any deferred compensation arrangement or pension plan; or
- any other compensation from the Policyholder.

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Rehabilitation Program means a program that has been approved by us for the purpose of helping You return to work. It may include, but is not limited to, Your participation in one or more of the following activities:

- return to work on a modified basis with a goal of resuming employment for which You are reasonably qualified by training, education, experience and past earnings;
- on-site job analysis;
- job modification;
- training to improve job-seeking skills;
- vocational assessment;
- short-term skills enhancement;
- vocational training; or
- restorative therapies to improve functional capacity to return to work.

Sickness means illness, disease or pregnancy, including complications of pregnancy.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Spouse means Your lawful spouse.

We, Us and **Our** mean MetLife.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

You and **Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Full-Time employees of the Policyholder, excluding temporary or seasonal employees.

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

You will be eligible for the insurance described in this certificate on the later of:

1. January 1, 2023; and

2. the first day of the calendar month following the date You complete the Waiting Period of 30 days.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing an enrollment form.

DATE YOUR INSURANCE TAKES EFFECT

Rules for Noncontributory Insurance

When You complete the enrollment process for Noncontributory Insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the Noncontributory Insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Increase in Insurance

An increase in insurance due to an increase in Your earnings will take effect on the first day of the calendar year based on Your earnings in effect on the preceding October 1.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Decrease in Insurance

A decrease in insurance due to a decrease in earnings will take effect on the first day of the calendar year based on Your earnings in effect on the preceding October 1.

Changes in Your Disability Income Insurance will only apply to Disabilities commencing on or after the date of the change.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends; or
2. the date insurance ends for Your class; or
3. the end of the period for which the last premium has been paid for You; or
4. the last day of the calendar month in which You cease to be in an eligible class. You will cease to be in an eligible class on the last day of the calendar month in which You cease Active Work in an eligible class, if You are not Disabled on that date; or
5. the last day of the calendar month in which Your employment ends; or
6. the last day of the calendar month in which You retire in accordance with the Policyholder's retirement plan.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

Reinstatement of Disability Income Insurance

If Your insurance ends, You may become insured again as follows:

1. If Your insurance ends because:
   - You cease to be in an eligible class; or
   - Your employment ends; and

   You become a member of an eligible class again within 3 months of the date Your insurance ended, You will not have to complete a new Waiting Period or provide evidence of Your insurability.

2. If Your insurance ends because you cease making the required premium while on an approved Family and Medical Leave Act (FMLA) or other legally mandated leave of absence, and you become a member of an eligible class within 31 days of the earlier of:
   - The end of the period of leave You and the Policyholder agreed upon; or
   - The end of the eligible leave period required under the FMLA or other similar legally mandated leave of absence law,

   You will not have to complete a new Waiting Period or provide evidence of Your insurability.

3. In all other cases where Your insurance ends because the required premium for Your insurance has ceased to be paid, You will be required to provide evidence of Your insurability.

SPECIAL RULES FOR GROUPS PREVIOUSLY INSURED UNDER A PLAN OF DISABILITY INCOME INSURANCE

The following rules will apply if this Disability Income Insurance:

- replaces a plan of group disability income coverage provided to You by the Policyholder; or

- replaces a Prior Plan of group disability income coverage provided to You by a former employer; when the replacement results from the Policyholder's acquisition of, merger with or other combination with that employer.

Prior Plan means the plan of group disability income coverage that was provided to You by the Policyholder or the former employer on the day before the Replacement Date, and is being replaced by this insurance.

Replacement Date means the effective date of the Disability Income Insurance under the Group Policy.

Rules for When Insurance Takes Effect if You were Insured Under the Prior Plan on the Day Before the Replacement Date:

- **If You are Actively at Work on the day before the Replacement Date**, You will become insured for Disability Income Insurance under this certificate on the Replacement Date.
- **If You are <u>not</u> Actively at Work on such date because you are Disabled, and the Prior Plan that You were covered under on the day before the Replacement Date was an insured plan**, You will become insured for Disability Income Insurance under this certificate on the Replacement Date. However, if the Prior Plan that You were covered under on the day before the Replacement Date was a self-funded plan, You will become insured for Disability Income Insurance under this certificate on the date You return to Active Work.

  We will credit any time You accumulated toward the Elimination Period under the Prior Plan to the satisfaction of the Elimination Period required to be met under this certificate.

  Any benefits paid for such Disability will be equal to those that would have been payable to You under the Prior Plan less any amount for which the prior carrier is liable.

  Benefit payments for such Disability will end on the earliest of:

  - the date that payments end under the subsection DATE BENEFIT PAYMENTS END in this certificate; or
  - the date that payments would have ended under the provisions of the Prior Plan of Insurance.

- **If You are <u>not</u> Actively at Work on such date for any other reason,** You will become insured for Disability Income Insurance under this certificate on the date you return to Active Work, provided however, if You are on a Policyholder approved leave of absence on the Replacement Date, You will become insured for Disability Income Insurance on the Replacement Date. However, Your insurance under this certificate will end on the date Your approved leave of absence ends if You do not return to Active Work on such date.

Rules for When Insurance Takes Effect if You were <u>Not</u> Insured Under the Prior Plan on the Day Before the Replacement Date:

- You will be eligible for Disability Income Insurance under this certificate when you meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOU; and

- We will credit any time You accumulated under the Prior Plan toward the eligibility waiting period under the Prior Plan to the satisfaction of the eligibility waiting period required to be met under this certificate.

SPECIAL RULES FOR GROUPS PREVIOUSLY INSURED UNDER A PLAN OF DISABILITY INCOME INSURANCE (continued)

Rules for Temporary Recovery from a Disability under the Prior Plan

We will waive the Elimination Period that would otherwise apply to a Disability under this certificate if You:

- received benefits for a disability that began under the Prior Plan ("Prior Plan's disability");
- returned to work as an active Full-Time employee prior to the Replacement Date;
- become Disabled, as defined in this certificate, after the Replacement Date and within 90 days of Your return to work due to a sickness or accidental injury that is the same as or related to the Prior Plan's disability;
- are no longer entitled to benefit payments for the Prior Plan's disability since You are no longer insured under such Plan; and
- would have been entitled to benefit payments with no further elimination period under the Prior Plan, had it remained in force.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Policyholder for information regarding such legally mandated leave of absence laws.

AT THE POLICYHOLDER'S OPTION

The Policyholder has elected to continue insurance by paying premiums for employees who are not Disabled and cease Active Work in an eligible class for any of the reasons specified below.

Disability Income Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to injury or sickness, up to 3 months;

2. for the period You cease Active Work in an eligible class due to any other Policyholder approved leave of absence, up to 1 month.

   For purposes of this provision, leave of absence does not include a furlough. Furlough means an employer-mandated leave of absence.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

EVIDENCE OF INSURABILITY

No evidence of insurability is required for the insurance described in this certificate.

DISABILITY INCOME INSURANCE: SHORT TERM BENEFITS

If You become Disabled while insured, Proof of Disability must be sent to Us. When We receive such Proof, We will review the claim. If We approve the claim, We will pay the Weekly Benefit up to the Maximum Benefit Period shown in the SCHEDULE OF BENEFITS, subject to the Date Benefit Payments End section.

To verify that You continue to be Disabled without interruption after Our initial approval of the Disability claim, We may periodically request that You send Us Proof that You continue to be Disabled. Such Proof may include physical exams, exams by independent medical examiners, in-home interviews, or functional capacity exams, as needed.

While You are Disabled, the Weekly Benefits described in this certificate will not be affected if:

- Your insurance ends; or
- the Group Policy is amended to change the plan of benefits for Your class.

BENEFIT PAYMENT

If We approve Your claim, benefits will begin to accrue on the day after the day You complete Your Elimination Period. We will pay the first Weekly Benefit one week after the date benefits begin to accrue. We will make subsequent payments weekly thereafter so long as You remain Disabled. Payment will be based on the number of days You are Disabled during each week. For any partial week of Disability, payment will be made at the daily rate of 1/7th of the Weekly Benefit payable.

We will pay Weekly Benefits to You. If You die, We will pay the amount of any due and unpaid benefits as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who We Will Pay.

RECOVERY FROM A DISABILITY

For purposes of this subsection, the term Active Work only includes those days You actually work.

The provisions of this subsection will not apply if Your insurance has ended and You are eligible for coverage under another group short term disability plan.

If You Return to Active Work Before Completing Your Elimination Period

If You return to Active Work before completing Your Elimination Period and then become Disabled, You will have to complete a new Elimination Period.

If You Return to Active Work After Completing Your Elimination Period

If You return to Active Work after You begin to receive Weekly Benefits, We will consider You to have recovered from Your Disability.

If You return to Active Work for a period of 30 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. For the purpose of determining Your benefits, We will consider such Disability to be a part of the original Disability and will use the same Predisability Earnings and apply the same terms, provisions and conditions that were used for the original Disability.

REHABILITATION INCENTIVES

Rehabilitation Program Incentive

If You participate in a Rehabilitation Program, We will increase Your Weekly Benefit by an amount equal to 10% of the Weekly Benefit. We will do so before We reduce Your Weekly Benefit by any Other Income.

DISABILITY INCOME INSURANCE: SHORT TERM BENEFITS (continued)

Work Incentive

If You work while You are Disabled and receiving Weekly Benefits, Your Weekly Benefit will be adjusted as follows:

- Your Weekly Benefit will be increased by Your Rehabilitation Program Incentive, if any; and
- reduced by Other Income as defined in the DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.

Your Weekly Benefit as adjusted above will not be reduced by the amount You earn from working, except to the extent that such adjusted Weekly Benefit plus the amount You earn from working and the income You receive from Other Income exceeds 100% of Your Predisability Earnings as calculated in the definition of Disability. In addition, the Minimum Weekly Benefit will not apply.

Family Care Incentive

If You work or participate in a Rehabilitation Program while You are Disabled, We will reimburse You for up to $100 for weekly expenses You incur for each family member to provide:

- care for Your or Your Spouse's child, legally adopted child, or child for whom You or Your Spouse are legal guardian and who is:
  - living with You as part of Your household;
  - dependent on You for support; and
  - under age 13.

The child care must be provided by a licensed child care provider who may not be a member of Your immediate family or living in Your residence.

- care to Your family member who is:
  - living with You as part of Your household;
  - chiefly dependent on You for support; and
  - incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.

Care to Your family member may not be provided by a member of Your immediate family.

We will make reimbursement payments to You on a weekly basis starting with the 4th Weekly Benefit payment. Payments will not be made beyond the Maximum Benefit Period. We will not reimburse You for any expenses for which You are eligible for payment from any other source. You must send Proof that You have incurred such expenses.

Moving Expense Incentive

If You participate in a Rehabilitation Program while You are Disabled, We may reimburse You for expenses You incur in order to move to a new residence recommended as part of such Rehabilitation Program. Such expenses must be approved by Us in advance.

You must send Proof that You have incurred such expenses for moving.

We will not reimburse You for such expenses if they were incurred for services provided by a member of Your immediate family or someone who is living in Your residence.

DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT

We will reduce Your Disability benefit by the amount of all Other Income. Other Income includes the following (See notice page for persons working in District of Columbia):

1. any disability or retirement benefits which You receive because of Your disability or retirement under:
    - any state, public or federal employee retirement or disability plan, including State Teachers Retirement System (STRS); Public Employee Retirement System (PERS) or Federal Retirement System (FERS). You must apply for such benefits through the highest appeal level that is applicable to such benefits and available under the plan; or
    - any pension or disability plan of any other nation or political subdivision thereof.
2. any income received for disability or retirement under the Policyholder's Retirement Plan, to the extent that it can be attributed to the Policyholder's contributions;
3. any income received for disability under:
    - a group insurance policy to which the Policyholder has made a contribution, such as:
        - benefits for loss of time from work due to disability;
        - installment payments for permanent total disability;
    - a no-fault auto law for loss of income, excluding supplemental disability benefits;
    - a government compulsory benefit plan or program which provides payment for loss of time from Your job due to Your disability, whether such payment is made directly by the plan or program, or through a third party;
    - a self-funded plan, or other arrangement if the Policyholder contributes toward it or makes payroll deductions for it;
    - any sick pay, vacation pay or other salary continuation that the Policyholder pays to You;
    - workers' compensation or a similar law which provides periodic benefits;
    - occupational disease laws;
    - laws providing for maritime maintenance and cure;
    - unemployment insurance law or program;
    - any income that You receive from working while Disabled to the extent that such income reduces the amount of Your Weekly Benefit as described in REHABILITATION INCENTIVES. This includes but is not limited to salary, commissions, overtime pay, bonus or other extra pay arrangements from any source; and
    - recovery amounts that You receive for loss of income as a result of claims against a third party by judgment, settlement or otherwise including future earnings.
4. any government compulsory paid family leave program;
5. any employer sponsored paid family leave program.

DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT (continued)

REDUCING YOUR DISABILITY BENEFIT BY THE ESTIMATED AMOUNT OF YOUR GOVERNMENT COMPULSORY BENEFIT PLAN OR PROGRAM OR STRS, PERS OR FERS OR OTHER PUBLIC EMPLOYEE RETIREMENT OR DISABILITY BENEFIT PLAN OR PROGRAM (See notice page for persons working in District of Columbia):

If there is a reasonable basis for You to apply for benefits under a government compulsory plan or program or a federal, state or other public employee retirement or disability plan or program, including a STRS, PERS or FERS Retirement System, We expect You to apply for such benefits.

1. With respect to Government Compulsory Benefit Plans or Programs or STRS, PERS, FERS Benefit Plans or Programs, or to apply means to pursue such benefits through all applicable levels of appeal provided under such benefit plans or programs. You must, within 4 weeks following the date You become Disabled:

    - send Us Proof that You have applied for benefits under such plans or programs; and
    - sign a reimbursement agreement in which You agree to repay Us for any overpayments We may make to You under this insurance.

    If You do not satisfy the above requirements, We will reduce Your Disability benefit by the amount of such government compulsory benefit plan or program benefit, or STRS, PERS or FERS benefit that We estimate You are eligible to receive, provided that We have the reasonable means to make such an estimate. We will start to do this with the first Disability benefit payment under this certificate coincident with the date You were eligible to receive such government compulsory benefit plan or program benefit, or STRS, PERS or FERS benefits under any such plan or programs.

2. With respect to STRS, PERS or FERS benefit a government compulsory benefit plan or program, or if You do receive approval or final denial of Your claim for such benefits, You must notify Us immediately. We will adjust the amount of Your Disability benefit. You must promptly repay Us for any overpayment.

SINGLE SUM PAYMENT

If You receive Other Income in the form of a single sum payment, You must, within 10 days after receipt of such payment, give Written Proof satisfactory to Us of:

- the amount of the single sum payment;
- the amount to be attributed to income replacement; and
- the time period for which the payment applies.

When We receive such Proof, We will adjust the amount of Your Disability benefit.

If We do not receive the Written Proof described above, and We know the amount of the single sum payment, We may reduce Your Disability benefit by an amount equal to such benefit until the single sum has been exhausted.

If We adjust the amount of Your Disability benefit due to a single sum payment, the amount of the adjustment will not result in a benefit amount less than the minimum amount, except in the case of an Overpayment.

If You receive Other Income in the form of a single sum payment and We do not receive the Written Proof described above within 10 days after You receive the single sum payment, We will adjust the amount of Your Disability Benefit by the amount of such payment.

DISABILITY INCOME INSURANCE: INCOME WHICH WILL NOT REDUCE YOUR DISABILITY BENEFIT

We will not reduce Your Disability benefit to less than the Minimum Benefit shown in the SCHEDULE OF BENEFITS, or by:

- cost of living adjustments that are paid under any of the above sources of Other Income;
- reasonable attorney fees included in any award or settlement;
- group credit insurance;
- mortgage disability insurance benefits;
- early retirement benefits that have not been voluntarily taken by You;
- veteran's benefits;
- individual disability income insurance policies;
- benefits received from an accelerated death benefit payment; or
- amounts rolled over to a tax qualified plan unless subsequently received by You while You are receiving benefit payments.

DISABILITY INCOME INSURANCE: DATE BENEFIT PAYMENTS END

Your Disability benefit payments will end on the earliest of:

- the end of the Maximum Benefit Period;
- the date You are no longer Disabled;
- the date You die;
- the date You cease or refuse to participate in a Rehabilitation Program that We require and that is approved by Your Physician;
- the date You fail to have a medical exam requested by Us as described in the Physical Exams subsection of the GENERAL PROVISIONS section;
- the date You fail to provide required Proof of continuing Disability.

While You are Disabled, the benefits described in this certificate will not be affected if:

- Your insurance ends; or
- the Group Policy is amended to change the plan of benefits for Your class.

DISABILITY INCOME INSURANCE: EXCLUSIONS

We will not pay for any Disability caused or contributed to by:

1. war, whether declared or undeclared, or act of war, or participation in an insurrection, rebellion, riot or terrorist act;
2. intentionally self-inflicted injury;
3. attempted suicide; or
4. commission of or attempt to commit or taking part in a felony.

We will not pay Short Term Benefits for any Disability caused or contributed to by elective treatment or procedures, such as:

1. cosmetic surgery or treatment primarily to change appearance;
2. reversal of sterilization;
3. liposuction;
4. visual correction surgery; and
5. in vitro fertilization; embryo transfer procedure; or artificial insemination.

However, pregnancies and complications from any of these procedures will be treated as a Sickness.

FILING A DISABILITY INCOME INSURANCE CLAIM

The Policyholder should have a supply of claim forms. Obtain a claim form from the Policyholder and fill it out carefully. Return the completed claim form with the required Proof to the Policyholder.

If You are unable to report for Active Work due to a Sickness or accidental injury, and You think that You may be Disabled, You should contact MetLife or Your benefits representative to initiate a claim. We recommend that You do so no later than 14 days after the first day You are unable to report for Active Work so that Your claim can be processed in a timely manner.

When You file an initial claim for Disability Income Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 90 days after the end of the Elimination Period.

Notice of claim and Proof for Disability Income Insurance may also be given to Us by following the steps set forth below:

Step 1
You may give Us notice by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss.

Step 2
We will send a claim form to You and explain how to complete it. You should receive the claim form within 15 days of giving Us notice of claim.

Step 3
When You receive the claim form You should fill it out as instructed and return it with the required Proof described in the claim form. If You do not receive a claim form within 15 days after giving Us notice of claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

Step 4
You must give Us Proof not later than 90 days after the end of the Elimination Period.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given within 90 days after the end of the Elimination Period or if it is not reasonably possible to give notice of claim or Proof within such period, they are given as soon as is reasonably possible thereafter.

Items to be Submitted for a Disability Income Insurance Claim

When submitting Proof on an initial or continuing claim for Disability Income insurance, the following items may be required:

- documentation which must include, but is not limited to, the following information:
  - the date Your Disability started;
  - the cause of Your Disability;
  - the prognosis of Your Disability;
  - the continuity of Your Disability; and
  - Your application for:
    - Other Benefit Sources;
    - Federal Social Security disability benefits; and
    - Workers compensation benefits or benefits under a similar law.
  - Written authorization for Us to obtain and release medical, employment and financial information and any other items We may reasonably require to document Your Disability or to determine Your receipt of or eligibility for Other Benefit Sources;

FILING A DISABILITY INCOME INSURANCE CLAIM (continued)

- any and all medical information, including but not limited to:
  - x-ray films; and
  - photocopies of medical records, including:
  - histories,
  - physical, mental or diagnostic examinations; and
  - treatment notes; and
  - the names and addresses of all:
    - physicians and medical practitioners who have provided You with diagnosis, treatment or consultation;
    - hospitals or other medical facilities which have provided You with diagnosis, treatment or consultation;
    - pharmacies which have filled Your prescriptions within the past three years; and
- additional proof elements as required and described within the additional plan provisions for which you are filing a claim for benefits.

Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

Disability Income Benefit Payments: Who We Will Pay

We will make any benefit payments during Your lifetime to You or Your legal representative as Beneficiary. Any payment made in good faith will discharge Us from liability to the extent of such payment.

Upon Your death, We will pay any amount that is or becomes due to Your designated Beneficiary. If there is no Beneficiary designated or no surviving designated Beneficiary at Your death, We may determine the Beneficiary for any amount that is or becomes due, according to the following order:

1. Your Spouse, if alive;
2. Your child(ren), if there is no surviving Spouse;
3. Your parent(s), if there is no surviving child(ren);
4. Your sibling(s), if there is no surviving parent(s);
5. Your estate, if there is no such surviving sibling(s).

If more than one person is eligible to receive payment, We will divide the benefit amount in equal shares.

Payment to a minor or incompetent will be made to such person's guardian. The term "children" or "child" includes natural and adopted children.

Any periodic payments owed to Your estate may be paid in a single sum.

Entire Contract

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

We will not use Your statements which relate to insurability to contest Disability Insurance after it has been in force for 2 years during Your life, unless the statement is fraudulent. In addition, We will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during Your life, unless the statement is fraudulent.

GENERAL PROVISIONS (continued)

Misstatement of Age

If Your age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

Conformity with Law

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

Physical Exams

If a claim is submitted for insurance benefits, We have the right to ask the insured to be examined by a Physician(s) of Our choice as often as is reasonably necessary to process the claim. We will pay the cost of such exam.

Autopsy

We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

Overpayments for Disability Income Insurance

Recovery of Overpayments

We have the right to recover any amount that We determine to be an overpayment.

An overpayment occurs if We determine that:

- the total amount paid by Us on Your claim is more than the total of the benefits due to You under this certificate; or
- payment We made should have been made by another group plan.

If such overpayment occurs, You have an obligation to reimburse Us. Our rights and Your obligations in this regard are described in the reimbursement agreement that You are required to sign when You submit a claim for benefits under this certificate. This agreement:

- confirms that You will reimburse Us for all overpayments; and
- authorizes Us to obtain any information relating to sources of Other Income.

How We Recover Overpayments

We may recover the overpayment from You by:

- stopping or reducing any future Disability benefits, including the Minimum Benefit, payable to You or any other payee under the Disability sections of this certificate;
- demanding an immediate refund of the overpayment from You; and
- taking legal action.

If the overpayment results from Our having made a payment to You that should have been made under another group plan, We may recover such overpayment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

GENERAL PROVISIONS (continued)

Lien and Repayment

If You become Disabled and You receive Disability benefits under this certificate and You receive payment from a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate (for example, a judgment, settlement, payment from Federal Social Security or payment pursuant to Workers' Compensation laws), You shall reimburse Us from the proceeds of such payment up to an amount equal to the benefits paid to You under this certificate for such Disability. Our right to receive reimbursement from any such proceeds shall be a claim or lien against such proceeds and Our right shall provide Us with a first priority claim or lien over any such proceeds up to the full amount of the benefits paid to You under this certificate for such Disability. You agree to take all action necessary to enable Us to exercise Our rights under this provision, including, without limitation:

- notifying Us as soon as possible of any payment You receive or are entitled to receive from a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate;

- furnishing of documents and other information as requested by Us or any person working on Our behalf; and

- holding in escrow, or causing Your legal representative to hold in escrow, any proceeds paid to You or any party by a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate, up to an amount equal to the benefits paid to You under this certificate for such Disability, to be paid immediately to Us upon Your receipt of said proceeds.

You shall cooperate and You shall cause Your legal representative to cooperate with Us in any recovery efforts and You shall not interfere with Our rights under this provision. Our rights under this provision apply whether or not You have been or will be fully compensated by a third party for any Disability for which You received or are entitled to receive benefits under this certificate.

THE PRECEDING PAGE IS THE END OF THE CERTIFICATE.
THE FOLLOWING IS ADDITIONAL INFORMATION.

SPECIAL SERVICES

Return To Work Program

Goal of Rehabilitation

The goal of MetLife is to focus on employees' abilities, instead of disabilities. This "abilities" philosophy is the foundation of our Return to Work Program. By focusing on what employees can do versus what they can't, we can assist you in returning to work sooner than expected.

Incentives For Returning To Work

Your Disability plan is designed to provide clear advantages and financial incentives for returning to work either full-time or part-time, while still receiving a Disability benefit. In addition to financial incentives, there may be personal benefits resulting from returning to work. Many employees experience higher self-esteem and the personal satisfaction of being self-sufficient and productive once again. If it is determined that you are capable, but you do not participate in the Return to Work Program, your Disability benefits may cease.

Return to Work Services

As a covered employee you are automatically eligible to participate in our Return to Work Program. The program aims to identify the necessary training and therapy that can help you return to work. In many cases, this means helping you return to your former occupation, although rehabilitation can also lead to a new occupation which is better suited to your condition and makes the most of your abilities.
There is no additional cost to you for the services we provide, and they are tailored to meet your individual needs. These services include, but are not limited to, the following:

1. **Vocational Analyses**

   Assessment and counseling to help determine how your skills and abilities can be applied to a new or a modified job with your employer.

2. **Labor Market Surveys**

   Studies to find jobs available in the national economy that would utilize your abilities and skills. Also identify your earning potential for a specific occupation.

3. **Retraining Programs**

   Programs to facilitate return to your previous job, or to train you for a new job.

4. **Job Modifications**

   Analyses of job demands and functions to determine what modifications may be made to maximize your employment opportunities.

   This also includes changes in your job or modifications to help you perform the previous job or a similar vocation.

5. **Job Seeking Skills and Job Placement Assistance**

   Special training to identify abilities, set goals, develop resumes, polish interviewing techniques, and provide other career search assistance.

Return to Work Program Staff

The Case Manager handling your claim will coordinate return to work services. You may be referred to a clinical specialist, such as a Nurse Consultant, Psychiatric Clinical Specialist, or Vocational Rehabilitation Consultant, who has advanced training and education to help people with disabilities return to work. One of our clinical specialists will work with you directly, as well as with local support services and resources. They have returned hundreds of individuals to meaningful, gainful employment.

SPECIAL SERVICES

Rehabilitation Vendor Specialists
In many situations, the services of independent vocational rehabilitation specialists may be utilized. Services are obtained at no additional cost to you; MetLife pays for all vendor services. Selecting a rehabilitation vendor is based on:

1. attending physician's evaluation and recommendations;
2. your individual vocational needs; and
3. vendor's credentials, specialty, reputation and experience.

When working with vendors, we continue to collaborate with you and your doctor to develop an appropriate return to work plan.

MetLife

Delaware American Life Insurance Company
MetLife Health Plans, Inc.
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.
Metropolitan General Insurance Company
Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

SECTION 2: Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

SECTION 3: Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life insurers, a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

SECTION 4: How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB, Inc. ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's

file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

SECTION 6: Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

SECTION 7: HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

SECTION 8: Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. We will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

SECTION 9: Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE CLUBCORP USA, INC. DISABILITY INSURANCE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

ERISA INFORMATION

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

ClubCorp USA, Inc.

5221 North O'Conner Blvd. Suite 300

Irving, TX 75039

EMPLOYER IDENTIFICATION NUMBER: 75-2114856

PLAN NUMBER	COVERAGE	PLAN NAME
501	All Coverages	ClubCorp Health Benefits Plan, a Health and Welfare Benefit Plan

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

MetLife is liable for any benefits under the Plan. The group policy specifies the time when and the circumstances under which MetLife is liable for Disability Income Insurance: Short Term Benefits.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the rights to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event Your insurance ends in accordance with the DATE YOUR INSURANCE ENDS subsection of Your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife certificate.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 1st and ending on the following December 31st.

CLAIMS INFORMATION

Disability Benefits Claims

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Claim Submission

For claims for disability benefits, the claimant must report the claim to MetLife and, if requested, complete the appropriate claim form. The claimant must also submit the required proof as described in the "Filing A Claim" section of the certificate.

Claim forms requested by MetLife must be submitted in accordance with the instructions on the claim form.

Initial Determination

After you submit a claim for disability benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

FUTURE OF THE PLAN

It is hoped that This Plan will be continued indefinitely, but ClubCorp USA, Inc. reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of ClubCorp USA, Inc. shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE RIDER

Group Policy No.: **119217-1-G**

Policyholder: **ClubCorp USA, Inc.**

Effective Date: **January 1, 2024**

The certificate is changed as follows:

Applicable to Disability Insurance: Short Term Benefit for all Full-Time Employees.

In the **SCHEDULE OF BENEFITS**, replace **BENEFIT, BENEFIT AMOUNT AND HIGHLIGHTS** with the following:

"BENEFIT	**BENEFIT AMOUNT AND HIGHLIGHTS**
Disability Income Insurance For You: Short Term Benefits	
Weekly Benefit……	66.67% of the first $1,500 of Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section
Maximum Weekly Benefit……..	$1,500
Minimum Weekly Benefit……	10% of the Weekly Benefit before reductions for Other Income Benefits or $25, whichever is greater. The minimum weekly benefit is subject to the overpayments and rehabilitation incentive subsections of this Certificate
Elimination Period……	**For Injury** • 14 days of Disability. **For Sickness** • 14 days of Disability.
Maximum Benefit Period……	11 weeks
Rehabilitation Incentives……	Yes"

This rider is to be attached to and made part of the certificate.

Voluntary Long-Term Disability – MetLife Plan

Long-Term Disability insurance replaces a portion of your income when you are unable to work due to a qualified illness or non-work-related injury. Invited provides you with the opportunity to elect Long-Term Disability (LTD) through MetLife.

You must be in one of the following positions to be eligible to participate in the LTD plan:

- Home Office and Salaried Employees
- General Managers, Club Managers, or
- Salaried Department Heads who are primarily responsible for managing a department, such as (but not limited to): Athletic Director, Executive Chef, F&B Director, Golf Course Superintendent, Head Golf and Tennis Pro, Membership Director, Private Events Director or Service Director.

Long-Term Disability Benefits at a Glance	
Monthly Benefit	60% of monthly earnings, maximum $10,000
Elimination Period	90 Days
Benefit Duration	To age 65
Pre-Existing Condition Limitation	6/12

The above information is a summary only. Please refer to your Certificate of Coverage for complete details of Plan benefits, limitations and exclusions.

Long-Term Disability Cost	
Employee age as of January 1, 2024	Monthly Rate per $100 Monthly Benefit
	$0.413

Calculate Your Long-Term Disability Rate:

35-year-old employee with $40,000 annual salary

$40,000 Salary ÷ 12 Months = $3,333.33
$3,333.33 /$100 Monthly Benefit = $33.33
$33.33 x $0.413 = $13.77 per month

$13.77 x 12 ÷ 26 = **$3.18 per paycheck**

Pre-Existing Conditions

A pre-existing condition is an injury or illness for which you have received advice or treatment from a doctor within 6 months prior to the effective date of your insurance plan.

View the LTD Insurance Certificate by clicking **here**.

YOUR BENEFIT PLAN

ClubCorp USA, Inc.

All Full-Time Corporate Employees and Department Heads at Clubs

Disability Income Insurance: Long Term Benefits

Certificate Date: January 1, 2021

Certificate Number 1

ClubCorp USA, Inc.
3030 LBJ Freeway Suite 600
Dallas, TX 75234

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

ClubCorp USA, Inc.



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

Policyholder:	ClubCorp USA, Inc.
Group Policy Number:	119217-1-G
Type of Insurance:	Disability Income Insurance: Long Term Benefits
MetLife Toll Free Number(s): For Claim Information	FOR DISABILITY INCOME CLAIMS: 1-800-GET-MET8

THIS CERTIFICATE ONLY DESCRIBES DISABILITY INSURANCE.

FOR CALIFORNIA RESIDENTS: REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON YOUR EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

For New Hampshire Residents: 30 Day Right to Examine Certificate.
Please read this Certificate. You may return the Certificate to Us within 30 days from the date You receive it. If you return it within the 30 day period, the Certificate will be considered never to have been issued and We will refund any premium paid for insurance under this Certificate.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

NOTICE FOR RESIDENTS OF TEXAS

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Metropolitan Life Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Corporate Consumer Relations Department at 1-800-438-6388

Toll-free: 1-800-438-6388

Email: Johnstown_Complaint_Referrals@metlife.com

Mail: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Metropolitan Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388

Teléfono gratuito: 1-800-438-6388

Correo electrónico: Johnstown_Complaint_Referrals@metlife.com

Dirección postal: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

NOTICE FOR RESIDENTS OF ALL STATES

WORKERS' COMPENSATION
This certificate does not replace or affect any requirement for coverage by workers' compensation insurance.

MANDATORY DISABILITY INCOME BENEFIT LAWS
For Residents of California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico
This certificate does not affect any requirement for any government mandated temporary disability income benefits law.

NOTICE FOR RESIDENTS OF ARKANSAS

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
Consumer Services Division
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR METLIFE AT:

METROPOLITAN LIFE INSURANCE COMPANY
ATTN: CONSUMER RELATIONS DEPARTMENT
500 SCHOOLHOUSE ROAD
JOHNSTOWN, PA 15904

1-800-438-6388

IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA DEPARTMENT OF INSURANCE DEPARTMENT AT:

DEPARTMENT OF INSURANCE
CONSUMER SERVICES
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013

WEBSITE: http://www.insurance.ca.gov/

1-800-927-4357 (within California)
1-213-897-8921 (outside California)

NOTICE FOR RESIDENTS OF CONNECTICUT

MANDATORY REHABILITATION

This certificate contains a mandatory rehabilitation provision, which may require you to participate in vocational training or physical therapy when appropriate.

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

NOTICE FOR RESIDENTS OF IDAHO

If You have a question concerning Your coverage or a claim, first contact the Policyholder. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife, You may write to:

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company

1-800-438-6388

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance

Consumer Services Division

311 West Washington Street, Suite 300

Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at www.in.gov/idoi

NOTICE FOR RESIDENTS OF MAINE

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as for nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this certificate to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, You or any person authorized to act on Your behalf may request reinstatement of the certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

NOTICE FOR MASSACHUSETTS RESIDENTS

CONTINUATION OF DISABILITY INCOME INSURANCE

1. If Your Disability Income Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.

2. If Your Disability Income Insurance ends because:

    - You cease to be in an Eligible Class; or
    - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your Disability Income Insurance under the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

NOTICE FOR RESIDENTS OF ALL STATES

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

NOTICE FOR RESIDENTS OF UTAH

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 in disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

NOTICE FOR RESIDENTS OF THE STATE OF VERMONT

Vermont law provides that the following apply to Your certificate:

Domestic Partner means each of two people, one of whom is an Employee of the Policyholder, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "**Spouse**" appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

NOTICE FOR RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife
200 Park Avenue
New York, New York 10166
Attn: Corporate Consumer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:
1-800-438-6388

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance
Life and Health Division
P.O. Box 1157
Richmond, VA 23218-1157
1-804-371-9691 - phone
1-877-310-6560 - toll-free
1-804-371-9944 - fax
www.scc.virginia.gov - web address
BureauOfInsurance@scc.virginia.gov - email

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

NOTICE FOR RESIDENTS OF THE STATE OF WASHINGTON

Washington law provides that the following apply to Your certificate:

Wherever the term "**Spouse"** appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Domestic Partner means each of two people, one of whom is an Employee of the Policyholder, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If You are having problems with Your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve Your problem.

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, New York 10166
1-800-438-6388

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.

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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You will only be insured for the benefits:

- for which You become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS

Disability Income Insurance For You: Long Term Benefits

Monthly Benefit…….…..	60% of the first $16,667 of Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section
Maximum Monthly Benefit……	$10,000
Minimum Monthly Benefit……	10% of the Monthly Benefit before reductions for Other Income Benefits or $100, whichever is greater, subject to the Overpayments and Rehabilitation Incentive subsections of this certificate
Elimination Period…….	90 Days

Maximum Benefit Period*

the later of:

- Your Normal Retirement Age;

or

- the period shown below:

Age on Date of Your Disability	Benefit Period
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

*The Maximum Benefit Period is subject to the LIMITED DISABILITY BENEFITS and DATE BENEFIT PAYMENTS END sections.

Rehabilitation Incentives …..……	Yes

Additional Benefits:

Single Sum Payment in the Event of Your Death ……..	Yes
Alternative Benefit Payment, At Our Option ……	Yes

SICK LEAVE or **SALARY CONTINUANCE PLAN** means a plan that:

1. is established and maintained by the Policyholder for the benefit of Employees; and
2. continues payment of all or part of an Insured Employee's Pre-disability Income for a specified period after he or she becomes Disabled.

It does **not** include compensation the Policyholder pays an Insured Employee for work actually performed during a Disability.

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a full-time basis. This must be done at:

- the Policyholder's place of business;
- an alternate place approved by the Policyholder; or
- a place to which the Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Policyholder approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Appropriate Care and Treatment means medical care and treatment that is:

- given by a Physician whose medical training and clinical specialty are appropriate for treating Your Disability;
- consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;
- consistent with a Physician's diagnosis of Your Disability; and
- intended to maximize Your medical and functional improvement.

Beneficiary means the person(s) to whom We will pay insurance as determined in accordance with the GENERAL PROVISIONS section.

Consumer Price Index means the CPI-W, the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the CPI-W is discontinued or replaced, We reserve the right to substitute any other comparable index.

Contributory Insurance means insurance for which the Policyholder requires You to pay any part of the premium.

Contributory Insurance includes: Disability Income Insurance: Long Term Benefits.

Disabled or **Disability** means that, due to Sickness or as a direct result of accidental injury:

- You are receiving Appropriate Care and Treatment and complying with the requirements of such treatment; and
- You are, during the Elimination Period and the next 24 months of Sickness or accidental injury:
  - unable to earn more than 80% of Your Predisability Earnings at Your Own Occupation for any employer in the National Economy; and
  - unable to perform each of the material duties of Your Own Occupation for any employer in the National Economy; and
- You are, after such period:
  - unable to earn more than 60% of Your Predisability Earnings at any gainful occupation for any employer in the National Economy; and
  - unable to perform the duties of any gainful occupation for any employer in the National Economy for which You are reasonably qualified taking into account Your training, education and experience.

For purposes of determining whether a Disability is the direct result of an accidental injury, the Disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes.

If You are Disabled and have received a Monthly Benefit for 12 months, We will adjust Your Predisability Earnings only for the purposes of determining whether You continue to be Disabled and for calculating the Return to Work Incentive, if any. We will make the initial adjustment as follows:

We will add to Your Predisability Earnings an amount equal to the product of:

- Your Predisability Earnings times the lesser of:
  - 10%; or
  - the annual rate of increase in the Consumer Price Index for the prior calendar year.

Annually thereafter, We will add an amount to Your adjusted Predisability Earnings calculated by the method set forth above but substituting Your adjusted Predisability Earnings from the prior year for Your Predisability Earnings. **This adjustment is not a cost of living benefit**.

If Your occupation requires a license, the fact that You lose Your license for any reason will not, in itself, constitute Disability.

Elimination Period means the period of Your Disability during which We do not pay benefits. The Elimination Period begins on the day You become Disabled and continues for the period shown in the SCHEDULE OF BENEFITS.

National Economy means the economy in the continental United States.

Normal Retirement Age means that as defined by the federal Social Security Administration on the date Your Disability starts.

Own Occupation means the occupation You routinely perform that provides the primary source of Your earned income. In determining your Own Occupation, We will look at Your occupation as it is normally performed instead of how it is performed for any specific employer or in any specific location.

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. Such person must also be certified and/or registered if required by such jurisdiction.

The term does not include:

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse's:
  - parents;
  - children (natural, step or adopted);
  - siblings;
  - grandparents; or
  - grandchildren.

Policyholder's Retirement Plan means a plan which:

- provides retirement benefits to employees; and
- is funded in whole or in part by Policyholder contributions.

The term does not include:

- profit sharing plans;
- thrift or savings plans;
- non-qualified plans of deferred compensation;
- plans under IRC Section 401(k) or 457;
- individual retirement accounts (IRA);
- tax sheltered annuities (TSA) under IRC Section 403(b);
- stock ownership plans; or
- Keogh (HR-10) plans.

Predisability Earnings means:

- **for commission employees,** gross salary or wages You were earning from the Policyholder based on the most recent W-2, or if service of less than one year, the average paid for the period worked prior to Your last day of Active Work before Your Disability began, subject to any increase or decrease in insurance as described in the ELIGIBILITY PROVISIONS: INSURANCE FOR YOU, Increase in Insurance and Decrease in Insurance provisions. We calculate this amount on a monthly basis.

- **for all other employees,** gross salary or wages You were earning from the Policyholder based on Your average monthly wages from the prior October 1 through September 30, subject to any increase or decrease in insurance as described in the ELIGIBILITY PROVISIONS: INSURANCE FOR YOU, Increase in Insurance and Decrease in Insurance provisions. We calculate this amount on a monthly basis

The term includes:

- commissions You earned averaged over a 12 month period from October 1 thru September 30 before Disability began, or over the period of Your employment, if less; and
- contributions You were making through a salary reduction agreement with the Policyholder to any of the following:
  - an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
  - an executive non-qualified deferred compensation arrangement; and
  - Your fringe benefits under an IRC Section 125 plan; and
  - overtime pay.

The term does not include:

- awards and bonuses;
- the grant, award, sale, conversion and/or exercise of shares of stock or stock options;
- the Policyholder's contributions on Your behalf to any deferred compensation arrangement or pension plan; or
- any other compensation from the Policyholder.

DEFINITIONS (continued)

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Rehabilitation Program means a program that has been approved by us for the purpose of helping You return to work. It may include, but is not limited to, Your participation in one or more of the following activities:

- return to work on a modified basis with a goal of resuming employment for which You are reasonably qualified by training, education, experience and past earnings;
- on-site job analysis;
- job modification/accommodation;
- training to improve job-seeking skills;
- vocational assessment;
- short-term skills enhancement;
- vocational training; or
- restorative therapies to improve functional capacity to return to work.

Sickness means illness, disease or pregnancy, including complications of pregnancy.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Spouse means Your lawful spouse.

We, Us and **Our** mean MetLife.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

You and **Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

Class 1: Full-Time corporate employees and department heads at clubs who are employed Policyholder, including former corporate employees who are not department heads but have elected the Policyholder's long term disability plan, and who are classified by the Policyholder as Full-Time Employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder, excluding temporary or seasonal employees.

Class 2: Variable hour employees who are employed by the Policyholder and who are employees of the Policyholder who qualify as Full-Time Employees based on working an average of 30 hours or more per week during a particular Measurement Period.

Full-Time Employee means an employee who qualifies as full-time under the following eligibility rules: There are 2 categories of Full-Time Employees:

- Employees of the Policyholder who are classified by the Policyholder as full-time regular employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder.
- Employees of the Policyholder who are variable hour employees that qualify as Full-Time Employees based on working 30 hours or more per week during a particular Measurement Period.

See also Eligibility Definitions below.

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

For Eligible Class 1

If You are in an eligible class on January 1, 2021, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after January 1, 2021, You will be eligible for insurance on the day after the date You complete the Waiting Period of 89 days.

If You become a Full-Time corporate employee or department head after the date You are hired, You will not be required to satisfy a new waiting period and any waiting period days already satisfied will still apply.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

Your eligibility for insurance will continue, subject to the Date Your Insurance Ends section, until such time as Your employment ends or Your employment classification changes to a non-full-time status, as determined by the Policyholder based upon status classification changes and/or a reduction in hours worked.

For Eligible Class 2

Eligibility Rules – Newly Hired Employees Who Are Hired on or After January 1, 2021

If on the date of Your hire, You are classified as a variable hour employee by the Policyholder, You may later qualify for Full-Time Employee status if the Policyholder determines that You have worked an average of 30 or more hours per week during the Initial Measurement Period. If You qualify for Full-Time Employee status during the Initial Measurement Period, You will be eligible for insurance during the Initial Stability Period, provided that Your employment continues. Your eligibility for insurance will terminate, subject to the Date Your Insurance Ends section, at the end of the Initial Stability Period, unless the Policyholder determines that You re-qualify for Full-Time Employee status during an Ongoing Measurement Period.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

Eligibility Rules – Ongoing Employees

If You are classified on or after January 1, 2021 as a variable hour employee by the Policyholder following Your Initial Stability Period, You must work an average of 30 hours or more per week during any Ongoing Measurement Period. Your eligibility for insurance will terminate, subject to the Date Your Insurance Ends section, at the end of the Ongoing Stability Period, unless the Policyholder determines that You re-qualify for Full-Time Employee status during an Ongoing Measurement Period.

If You were not initially classified as a variable hour employee by the Policyholder on Your date of hire the following eligibility rules apply on and after January 1, 2021 regardless of whether You were eligible for insurance during the Initial Stability Period:

If You qualify for Full-Time Employee status by working an average of 30 or more hours per week as determined by the Policyholder during any Ongoing Measurement Period You will be eligible for insurance during the immediately following Ongoing Stability Period, provided that Your employment continues. Your eligibility for insurance will terminate, subject to the Date Your Insurance Ends section, at the end of the Ongoing Stability Period, unless the Policyholder determines that You re-qualify for Full-Time Employee status during an Ongoing Measurement Period.

Eligibility Definitions

For purposes of the above eligibility rules, the following terms and their meanings are indicated.

Initial Measurement Period means a period that starts with the first pay period that begins immediately after Your hire date, and ends on the last day of the pay period that contains the eleventh (11th) month anniversary of Your hire.

Initial Stability Period means a 12 month period that starts on the first day of the 13th calendar month following Your date of hire.

Ongoing Measurement Period means an annual 12 month period that starts on October 15th.

Ongoing Stability Period means the 12 month period that starts on the first day of the calendar year following the end of the immediately preceding Ongoing Measurement Period.

ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the required form. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

The insurance listed below is part of a flexible benefits plan established by the Policyholder. Subject to the rules of the flexible benefits plan and the Group Policy, You may enroll for:

- Disability Income Insurance: Long Term Benefits;

only when You are first eligible or during an annual enrollment period or if You have a Qualifying Event. You should contact the Policyholder for more information regarding the flexible benefits plan.

DATE YOUR INSURANCE THAT IS PART OF THE FLEXIBLE BENEFITS PLAN TAKES EFFECT

Enrollment When First Eligible

For new hires, if You complete the enrollment process within 89 days of becoming eligible, such insurance will take effect as follows:

If You are in Eligible Class 1, i.e., You are a full-time regular employee, such insurance will take effect on the date You become eligible, provided You are Actively at Work in Eligible Class 1 on that date.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

If You are in Eligible Class 2, i.e., You are a variable hour employee who has qualified for Full-Time Employee status by working an average of 30 hours or more per week as determined by the Policyholder during Your Initial Measurement Period, such insurance will take effect on the later of:

1. January 1, 2021; and
2. the first day of the Initial Stability Period

provided You are Actively at Work in Eligible Class 2 on that date.

If You are in Eligible Class 2 and have qualified for Full-Time Employee status by working an average of 30 hours or more per week as determined by the Policyholder during an Ongoing Measurement Period, insurance will take effect on the first day of the immediately following Ongoing Stability Period provided You are Actively at Work in Eligible Class 2 on that date.

If You do not complete the enrollment process within 89 days of becoming eligible, You will not be able to enroll for insurance until the next annual enrollment period, as determined by the Policyholder, following the date You first became eligible or if You have a Qualifying Event. At that time You will be able to enroll for insurance for which You are then eligible.

If You complete the enrollment process within 89 days of becoming eligible for insurance, such insurance will take effect on the date You become eligible for such insurance if You are Actively at Work on that date.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Enrollment During An Annual Enrollment Period

During any annual enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible. The insurance enrolled for during an annual enrollment period will take effect on the first day of the calendar year following the annual enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date an amount of insurance would otherwise take effect, that amount of insurance will take effect on the day You resume Active Work.

Enrollment Due to a Qualifying Event

Under the rules of the flexible benefit plan, You may enroll for insurance for which You are eligible or change the amount of Your insurance between annual enrollment periods only if You have a Qualifying Event.

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment; or
- the death of a dependent.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for, or changes to Your insurance made as a result of a Qualifying Event will take effect on the date of the Qualifying Event, if You are Actively at Work on that date.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

Increase in Insurance

An increase in insurance due to an increase in Your earnings will take effect on January 1 based on the increase in Your earnings as of October 1 of the prior year.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Decrease in Insurance

A decrease in insurance due to a decrease in Your earnings will take effect on January 1 based on the decrease in Your earnings as of October 1 of the prior year.

Changes in Your Disability Income Insurance will only apply to Disabilities commencing on or after the date of the change.

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends; or
2. the date insurance ends for Your class; or
3. the end of the period for which the last premium has been paid for You; or
4. the date You cease to be in an eligible class. You will cease to be in an eligible class on the date You cease Active Work in an eligible class, if You are not Disabled on that date; or
5. the date Your employment ends; or
6. the date You retire in accordance with the date Your employment ends; or
7. the date You cease to be Actively at Work in Eligible Class 1 and provided that You have not become eligible as a variable hour employee under Eligible Class 2, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
8. the end of the last Stability Period for which You have been determined by the Policyholder to be a variable hour employee as a member of Eligible Class 2 due to Your work in a prior Measurement Period and provided that You have not become eligible as a full-time regular employee under Eligible Class 1, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

Reinstatement of Disability Income Insurance

If Your insurance ends, You may become insured again as follows:

1. If Your insurance ends because:

   - You cease to be in an eligible class; or
   - Your employment ends; and

   You become a member of an eligible class again within 3 months of the date Your insurance ended, You will not have to complete a new Waiting Period or provide evidence of Your insurability.

2. If Your insurance ends because you cease making the required premium while on an approved Family and Medical Leave Act (FMLA) or other legally mandated leave of absence, and you become a member of an eligible class within 31 days of the earlier of:

   - The end of the period of leave You and the Policyholder agreed upon; or
   - The end of the eligible leave period required under the FMLA or other similar legally mandated leave of absence law,

   You will not have to complete a new Waiting Period or provide evidence of Your insurability.

3. In all other cases where Your insurance ends because the required premium for Your insurance has ceased to be paid, You will be required to provide evidence of Your insurability.

If You become insured again as described in either item 1 or 2 above, the limitation for Pre-existing Conditions will be applied as if Your insurance had remained in effect with no interruption.

SPECIAL RULES FOR GROUPS PREVIOUSLY INSURED UNDER A PLAN OF DISABILITY INCOME INSURANCE

The following rules will apply if this Disability Income Insurance:

- replaces a plan of group disability income coverage provided to You by the Policyholder; or

- replaces a Prior Plan of group disability income coverage provided to You by a former employer; when the replacement results from the Policyholder's acquisition of, merger with or other combination with that employer.

Prior Plan means the plan of group disability income coverage that was provided to You by the Policyholder or the former employer on the day before the Replacement Date, and is being replaced by this insurance.

Replacement Date means the effective date of the Disability Income Insurance under the Group Policy.

Rules for When Insurance Takes Effect if You were Insured Under the Prior Plan on the Day Before the Replacement Date:

- **If You are Actively at Work on the day before the Replacement Date**, You will become insured for Disability Income Insurance under this certificate on the Replacement Date.
- **If You are <u>not</u> Actively at Work on such date because you are Disabled, and the Prior Plan that You were covered under on the day before the Replacement Date was an insured plan**, You will become insured for Disability Income Insurance under this certificate on the Replacement Date. However, if the Prior Plan that You were covered under on the day before the Replacement Date was a self-funded plan, You will become insured for Disability Income Insurance under this certificate on the date You return to Active Work.

  We will credit any time You accumulated toward the Elimination Period under the Prior Plan to the satisfaction of the Elimination Period required to be met under this certificate.

  Any benefits paid for such Disability will be equal to those that would have been payable to You under the Prior Plan less any amount for which the prior carrier is liable.

  Benefit payments for such Disability will end on the earliest of:

  - the date that payments end under the subsection DATE BENEFIT PAYMENTS END in this certificate; or
  - the date that payments would have ended under the provisions of the Prior Plan of Insurance.

- **If You are <u>not</u> Actively at Work on such date for any other reason,** You will become insured for Disability Income Insurance under this certificate on the date you return to Active Work, provided however, if You are on a Policyholder approved leave of absence on the Replacement Date, You will become insured for Disability Income Insurance on the Replacement Date. However, Your insurance under this certificate will end on the date Your approved leave of absence ends if You do not return to Active Work on such date.

Rules for When Insurance Takes Effect if You were <u>Not</u> Insured Under the Prior Plan on the Day Before the Replacement Date:

- You will be eligible for Disability Income Insurance under this certificate when you meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOU; and

- We will credit any time You accumulated under the Prior Plan toward the eligibility waiting period under the Prior Plan to the satisfaction of the eligibility waiting period required to be met under this certificate.

SPECIAL RULES FOR GROUPS PREVIOUSLY INSURED UNDER A PLAN OF DISABILITY INCOME INSURANCE (continued)

Rules for Pre-existing Conditions

In determining whether a Disability is due to a Pre-existing Condition, We will credit You for any time You were insured under the Prior Plan. If Your Disability is due to a Pre-existing Condition as described in this certificate, but would not have been due to a pre-existing condition under the Prior Plan, We will pay a benefit equal to the lesser of:

- the benefit amount under this certificate; or
- the disability income insurance benefit that would have been payable to You under the Prior Plan.

If Your Disability would have been due to a pre-existing condition under the Prior Plan, it will be treated as having been caused by a Pre-existing Condition under this certificate.

Rules for Temporary Recovery from a Disability under the Prior Plan

We will waive the Elimination Period that would otherwise apply to a Disability under this certificate if You:

- received benefits for a disability that began under the Prior Plan (“Prior Plan’s disability”);
- returned to work as an active Full-Time employee prior to the Replacement Date;
- become Disabled, as defined in this certificate, after the Replacement Date and within 90 days of Your return to work due to a sickness or accidental injury that is the same as or related to the Prior Plan’s disability;
- are no longer entitled to benefit payments for the Prior Plan’s disability since You are no longer insured under such Plan; and
- would have been entitled to benefit payments with no further elimination period under the Prior Plan, had it remained in force.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Policyholder for information regarding such legally mandated leave of absence laws.

AT THE POLICYHOLDER'S OPTION

The Policyholder has elected to continue insurance by paying premiums for employees who are not Disabled and cease Active Work in an eligible class for any of the reasons specified below.

Disability Income Insurance will continue for the period You cease Active Work in an eligible class due to injury or sickness, up to 6 months.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

DISABILITY INCOME INSURANCE: LONG TERM BENEFITS

If You become Disabled while insured, Proof of Disability must be sent to Us. When We receive such Proof, We will review the claim. If We approve the claim, We will pay the Monthly Benefit up to the Maximum Benefit Period shown in the SCHEDULE OF BENEFITS, subject to the DATE BENEFIT PAYMENTS END section.

To verify that You continue to be Disabled without interruption after Our initial approval, We may periodically request that You send Us Proof that You continue to be Disabled. Such Proof may include physical exams, exams by independent medical examiners, in-home interviews or functional capacity exams, as needed.

While You are Disabled, the Monthly Benefit described in this certificate will not be affected if:

- Your insurance ends; or
- the Group Policy is amended to change the plan of benefits for Your class.

BENEFIT PAYMENT

If We approve Your claim, benefits will begin to accrue on the day after the day You complete Your Elimination Period. We will pay the first Monthly Benefit one month after the date benefits begin to accrue. We will make subsequent payments monthly thereafter so long as You remain Disabled. Payment will be based on the number of days You are Disabled during each month and will be pro-rated for any partial month of Disability.

We will pay Monthly Benefits to You. If You die, We will pay the amount of any due and unpaid benefits as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who We Will Pay.

While You are receiving Monthly Benefits, You will not be required to pay premiums for the cost of any disability income insurance defined as Contributory Insurance.

RECOVERY FROM A DISABILITY

If You return to Active Work, We will consider You to have recovered from Your Disability.

The provisions of this subsection will not apply if Your insurance has ended and You are eligible for coverage under another group long term disability plan.

If You Return to Active Work Before Completing Your Elimination Period

If You return to Active Work before completing Your Elimination Period for a period of 30 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. We will count those days towards the completion of Your Elimination Period.

If You return to Active Work for a period of more than 30 days, and then become Disabled again, You will have to complete a new Elimination Period.

For purposes of this provision, the term Active Work only includes those days You actually work.

If You Return to Active Work After Completing Your Elimination Period

If You return to Active Work after completing Your Elimination Period for a period of 180 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. For the purpose of determining Your benefits, We will consider such Disability to be a part of the original Disability and will use the same Predisability Earnings and apply the same terms, provisions and conditions that were used for the original Disability.

If You return to Active Work for a period of more than 180 days and then become Disabled again, You will have to complete a new Elimination Period.

For purposes of this provision, the term Active Work includes all of the continuous days which follow Your return to work for which You are not Disabled.

REHABILITATION INCENTIVES

Rehabilitation Program Incentive

If You participate in a Rehabilitation Program, We will increase Your Monthly Benefit by an amount equal to 10% of the Monthly Benefit. We will do so before We reduce Your Monthly Benefit by any other income.

Work Incentive

While You are Disabled, We encourage You to work. If You work while You are Disabled and receiving Monthly Benefits, Your Monthly Benefit will be adjusted as follows:

- Your Monthly Benefit will be increased by Your Rehabilitation Program Incentive, if any; and
- reduced by Other Income as defined in the DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.

Your Monthly Benefit as adjusted above will not be reduced by the amount You earn from working, except to the extent that such adjusted Monthly Benefit plus the amount You earn from working and the income You receive from Other Income exceeds 100% of Your Predisability Earnings as calculated in the definition of Disability. In addition, the Minimum Monthly Benefit will not apply.

Limit on Work Incentive

After the first 12 months following Your return to work, We will reduce Your Monthly Benefit by 50% of the amount You earn from working while Disabled.

Family Care Incentive

If You work or participate in a Rehabilitation Program while You are Disabled, We will reimburse You for up to $400 for monthly expenses You incur for each family member to provide:

- care for Your or Your Spouse's child, legally adopted child, or child for whom You or Your Spouse are legal guardian and who is:
  - living with You as part of Your household;
  - dependent on You for support; and
  - under age 13.

  The child care must be provided by a licensed child care provider who may not be a member of Your immediate family or living in Your residence.

- care to Your family member who is:
  - living with You as part of Your household;
  - chiefly dependent on You for support; and
  - incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.

Care to Your family member may not be provided by a member of Your immediate family.

We will make reimbursement payments to You on a monthly basis starting with the first Monthly Benefit payment until You have received 12 Monthly Benefit Payments. Payments will not be made beyond the Maximum Benefit Period. We will not reimburse You for any expenses for which You are eligible for payment from any other source. You must send Proof that You have incurred such expenses.

Moving Expense Incentive

If You participate in a Rehabilitation Program while You are Disabled, We may reimburse You for expenses You incur in order to move to a new residence recommended as part of such Rehabilitation Program. Such expenses must be approved by Us in advance.

You must send Proof that You have incurred such expenses for moving.

We will not reimburse You for such expenses if they were incurred for services provided by a member of Your immediate family or someone who is living in Your residence.

DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT

We will reduce Your Disability benefit by the amount of all Other Income. Other Income includes the following:

1. any disability or retirement benefits which You, Your Spouse or child(ren) receive or are eligible to receive because of Your disability or retirement under:
    - Federal Social Security Act;
    - Railroad Retirement Act;
    - any state, public or federal employee retirement or disability plan, including State Teachers Retirement System (STRS); Public Employee Retirement System (PERS) or Federal Retirement System (FERS). You must apply for such benefits through the highest appeal level that is applicable to such benefits and available under the plan; or
    - any pension or disability plan of any other nation or political subdivision thereof.
2. any income received for disability or retirement under the Policyholder's Retirement Plan, to the extent that it can be attributed to the Policyholder's contributions.
3. any income received for disability under:
    - a group insurance policy to which the Policyholder has made a contribution, such as:
        - benefits for loss of time from work due to disability;
        - installment payments for permanent total disability;
    - a no-fault auto law for loss of income, excluding supplemental disability benefits;
    - a government compulsory benefit plan or program which provides payment for loss of time from Your job due to Your disability, whether such payment is made directly by the plan or program, or through a third party;
    - a self-funded plan, or other arrangement if the Policyholder contributes toward it or makes payroll deductions for it;
    - any sick pay, vacation pay or other salary continuation that the Policyholder pays to You;
    - workers' compensation or a similar law which provides periodic benefits;
    - occupational disease laws;
    - laws providing for maritime maintenance and cure;
    - unemployment insurance law or program.
4. any income that You receive from working while Disabled to the extent that such income reduces the amount of Your Monthly Benefit as described in REHABILITATION INCENTIVES. This includes but is not limited to salary, commissions, overtime pay, bonus or other extra pay arrangements from any source.
5. recovery amounts that You receive for loss of income as a result of claims against a third party by judgment, settlement or otherwise including future earnings.

DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT (continued)

REDUCING YOUR DISABILITY BENEFIT BY THE ESTIMATED AMOUNT OF YOUR FEDERAL SOCIAL SECURITY BENEFIT, GOVERNMENT COMPULSORY BENEFIT PLAN OR PROGRAM OR STRS, PERS OR FERS OR OTHER PUBLIC EMPLOYEE RETIREMENT OR DISABILITY BENEFIT PLAN OR PROGRAM

If there is a reasonable basis for You to apply for benefits under the Federal Social Security Act, a government compulsory plan or program or a federal, state or other public employee retirement or disability plan or program, including a STRS, PERS or FERS Retirement System, We expect You to apply for such benefits.

1. With respect to benefits under the Federal Social Security Act, to apply means to pursue such benefits until You receive approval from the Federal Social Security Administration, or a notice of denial of benefits from an administrative law judge. We will reduce the amount of Your Disability benefit by the amount of Federal Social Security benefits We estimate that You, Your Spouse or child(ren) are eligible to receive because of Your Disability or retirement. We will start to do this after You have received 24 months of Disability benefit payments, unless We have received:

    - approval of Your claim for Federal Social Security benefits; or
    - a notice of denial of such benefits indicating that all levels of appeal have been exhausted.

    You must, within 6 months following the date You became Disabled:

    - send Us Proof that You have applied for Federal Social Security benefits;
    - sign a reimbursement agreement in which You agree to repay Us for any overpayments We may make to You under this insurance; and
    - sign a release that authorizes the Federal Social Security Administration to provide information directly to Us concerning Your Federal Social Security benefits eligibility.

    If You do not satisfy the above requirements, We will reduce Your Disability benefits by such estimated Federal Social Security benefits starting with the first Disability benefit payment coincident with the date You were eligible to receive Federal Social Security benefits.

2. With respect to Government Compulsory Benefit Plans or Programs or STRS, PERS, FERS Benefit Plans or Programs, or to apply means to pursue such benefits through all applicable levels of appeal provided under such benefit plans or programs. You must, within 6 months following the date You become Disabled:

    - send Us Proof that You have applied for benefits under such plans or programs; and
    - sign a reimbursement agreement in which You agree to repay Us for any overpayments We may make to You under this insurance.

    If You do not satisfy the above requirements, We will reduce Your Disability benefit by the amount of such government compulsory benefit plan or program benefit, or STRS, PERS or FERS benefit that We estimate You, Your Spouse or child(ren) are eligible to receive, provided that We have the reasonable means to make such an estimate We will start to do this with the first Disability benefit payment under this certificate coincident with the date You were eligible to receive such government compulsory benefit plan or program benefit or STRS, PERS or FERS benefits under any such plan or programs.

3. With respect to benefits You have applied for under the Federal Social Security Act, a government compulsory benefit plan or program or a federal, state or other public employee retirement or disability plan or program, including a STRS, PERS or FERS Retirement System plan or program, or if You do receive approval or final denial of Your claim for such benefits, You must notify Us immediately. We will adjust the amount of Your Disability benefit. You must promptly repay Us for any overpayment.

DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT (continued)

SINGLE SUM PAYMENT

If You receive Other Income in the form of a single sum payment, You must, within 10 days after receipt of such payment, give Written Proof satisfactory to Us of:

- the amount of the single sum payment;
- the amount to be attributed to income replacement; and
- the time period for which the payment applies.

When We receive such Proof, We will adjust the amount of Your Disability benefit.

If We do not receive the Written Proof described above, and We know the amount of the single sum payment, We may reduce Your Disability benefit by an amount equal to such benefit until the single sum has been exhausted.

If We adjust the amount of Your Disability benefit due to a single sum payment, the amount of the adjustment will not result in a benefit amount less than the minimum amount, except in the case of an Overpayment.

If You receive Other Income in the form of a single sum payment and We do not receive the Written Proof described above within 10 days after You receive the single sum payment, We will adjust the amount of Your Disability Benefit by the amount of such payment.

DISABILITY INCOME INSURANCE: INCOME WHICH WILL NOT REDUCE YOUR DISABILITY BENEFIT

We will not reduce Your Disability benefit to less than the Minimum Benefit shown in the SCHEDULE OF BENEFITS, or by:

- cost of living adjustments that are paid under any of the above sources of Other Income;
- reasonable attorney fees included in any award or settlement. If the attorney fees are incurred because of Your successful pursuit of Social Security disability benefits, such fees are limited to those approved by the Social Security Administration;
- group credit insurance;
- mortgage disability insurance benefits;
- early retirement benefits that have not been voluntarily taken by You;
- veteran's benefits;
- individual disability income insurance policies;
- benefits received from an accelerated death benefit payment; or
- amounts rolled over to a tax qualified plan unless subsequently received by You while You are receiving benefit payments.

DISABILITY INCOME INSURANCE: DATE BENEFIT PAYMENTS END

Your Disability benefit payments will end on the earliest of:

- the end of the Maximum Benefit Period;
- the date benefits end as specified in the section entitled LIMITED DISABILITY BENEFITS;
- the date You are no longer Disabled;
- the date You die except for benefits paid under section entitled ADDITIONAL LONG TERM BENEFIT: SINGLE SUM PAYMENT IN THE EVENT OF YOUR DEATH;
- the date You cease or refuse to participate in a Rehabilitation Program that We require and that is approved by Your Physician;
- the date You fail to have a medical exam requested by Us as described in the Physical Exams subsection of the GENERAL PROVISIONS section;
- the date following 12 consecutive months of Disability for which You were entitled to receive Monthly benefit payments while You are living outside of the United States or Canada; or
- the date You fail to provide required Proof of continuing Disability.

While You are Disabled, the benefits described in this certificate will not be affected if:

- Your insurance ends; or
- the Group Policy is amended to change the plan of benefits for Your class.

DISABILITY INCOME INSURANCE

ADDITIONAL LONG TERM BENEFIT: SINGLE SUM PAYMENT IN THE EVENT OF YOUR DEATH

If You die while You are Disabled and You were entitled to receive Monthly Benefits under this certificate, Proof of Your death must be sent to Us. When We receive such Proof, We will pay the benefit described in this section.

BENEFIT AMOUNT

The benefit amount will be equal to 3 times the lesser of:

- the Monthly Benefit You receive for the calendar month immediately preceding Your death;
- the Monthly Benefit You were entitled to receive for the month You die, if You die during the first month that Disability benefits are payable.

We will reduce the benefit amount by any overpayment We are entitled to recover.

BENEFIT PAYMENT

Benefit payments will be made as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who We Will Pay.

DISABILITY INCOME INSURANCE

ADDITIONAL LONG TERM BENEFIT: ALTERNATIVE BENEFIT PAYMENT OFFER, AT OUR OPTION

If We approve Your claim for benefits under this certificate in accordance with the Long Term Benefit provisions of this certificate, We may offer to pay You a Disability benefit in the form of a lump sum benefit payment as an alternative to the Monthly Benefit payments described in the DISABILITY INCOME INSURANCE: LONG TERM BENEFITS provision of this certificate. If We determine on the basis of objective criteria applied to the particular facts and circumstances of Your claim that a lump sum payment is an appropriate option for Us to offer to You, We will make an offer of a lump sum payment to You. If You accept Our offer in Writing, Signed by You, and We make such lump sum benefit payment to You, no further Disability benefit payments will be made to You under this certificate. If You do not accept Our offer of a lump sum benefit payment, We will continue to administer Your claim in accordance with the terms and conditions of this certificate.

DISABILITY INCOME INSURANCE: PRE-EXISTING CONDITIONS

Pre-existing Condition means a Sickness or accidental injury for which You:

- received medical treatment, consultation, care, or services; or
- took prescribed medication or had medications prescribed;

in the 3 months before Your insurance under this certificate takes effect.

We will not pay benefits for a Disability that results from a Pre-existing Condition if You have been Actively at Work for less than 12 consecutive months after the date Your Disability insurance takes effect under this certificate.

DISABILITY INCOME INSURANCE: LIMITED DISABILITY BENEFITS

For Disability Due To Alcohol, Drug or Substance Abuse or Addiction; Mental and Nervous Disorders or Diseases; Neuromuscular, Musculoskeletal or Soft Tissue Disorders; Chronic Fatigue Syndrome and Related Disorders; Fibromyalgia or Self-Reported Conditions

If You are Disabled due to one or more of the following medical conditions described below, We will limit Your Disability benefits to a lifetime maximum equal to the lesser of:

- 24 months during Your lifetime for any one or more, or all of the above conditions; or
- the Maximum Benefit Period.

Subject to the Administration of Limited Disability Benefits for Disability Due to Alcohol, Drug or Substance Abuse or Addiction; Mental and Nervous Disorders or Diseases; Neuromuscular, Musculoskeletal or Soft Tissue Disorders; Chronic Fatigue Syndrome and Related Disorders; Fibromyalgia or Self-Reported Conditions as set forth below;

Your Disability benefits will be limited as stated above for:

1. Disability due to alcohol, drug or substance abuse or addiction, We require You to participate in an alcohol, drug or substance addiction recovery program recommended by a Physician. We will end Disability benefit payments at the earliest of the period described above or the date You cease, refuse to participate, or complete such recovery program.

2. Mental or Nervous Disorder or Disease that results from any cause, except for
   - Neurocognitive Disorders;
   - Schizophrenia.

If You are confined in a Hospital or Mental Health or Alcohol and Drug Facility at the end of the period shown above for which benefits are to be paid, We will continue Your Monthly Benefits until the end of Your Hospital or Mental Health or Alcohol and Drug Facility confinement.

For purposes of this provision, Mental Health or Alcohol and Drug Facility means a facility licensed in the jurisdiction in which it is located to provide care and treatment for a Mental or Nervous Disorder or Disease or a facility licensed to treat alcohol, drug or substance abuse or addiction. Such facility must provide care on a 24 hour a day basis under the supervision of a staff of Physicians, and must provide a broad range of nursing care on a 24 hour a day basis by or under the direction of a registered professional nurse.

3. Neuromuscular, Musculoskeletal or Soft Tissue disorders including, but not limited to, any disease or disorder of or injury to the spine or extremities and their surrounding soft tissue; sprains or strains of joints or their adjacent muscles, Carpel Tunnel Syndrome or other Repetitive Motion Disorders, unless the Disability has objective evidence of:
   - Myelopathies;
   - Myopathies;
   - Connective Tissue Disorder or Disease;
   - Tumors of the spine, bone or soft tissue;
   - Spinal Vascular Malformations; or
   - Spinal Cord Damage.

4. Chronic Fatigue Syndrome and Related Disorders;

5. Fibromyalgia;

6. Self-Reported Conditions.

DISABILITY INCOME INSURANCE: LIMITED DISABILITY BENEFITS (continued)

ADMINISTRATION OF LIMITED DISABILITY BENEFITS FOR DISABILITY DUE TO ALCOHOL, DRUG OR SUBSTANCE ABUSE OR ADDICTION, MENTAL AND NERVOUS DISORDERS OR DISEASES, NEUROMUSCULAR, MUSCULOSKELETAL OR SOFT TISSUE DISORDERS, CHRONIC FATIGUE SYNDROME AND RELATED DISORDERS, FIBROMYALGIA or SELF-REPORTED CONDITIONS

If no exception above applies, and You are Disabled as a result of more than one injury or Sickness for which Disability benefits are payable under this certificate, each of which are subject to the provisions of the Limited Disability Benefits section, the benefit limitation periods will run concurrently for all such conditions.

DEFINED TERMS USED IN LIMITED DISABILITY BENEFITS

Carpel Tunnel Syndrome means an entrapment median neuropathy, which causes pain, numbness, and other symptoms in the distribution of the median nerve due to its compression at the wrist.

Chronic Fatigue Syndrome means the clinically evaluated, unexplained persistent or relapsing chronic fatigue that is not substantially alleviated by rest. The diagnosis must be established following the Center for Disease Control current clinical criteria as of the date of Your Disability.

Connective Tissue Disorder or Disease means any of a group of diseases affecting the connective tissues of the body. These conditions include, but are not limited to, rheumatoid arthritis, Marfan syndrome, systemic lupus erythematosus, scleroderma, Ehlers-Danlos syndrome or polymyositis.

The diagnosis must be established using American College of Rheumatology current clinical criteria as of the date of Your Disability.

Fibromyalgia means a medical condition evidenced by widespread soft tissue pain. The diagnosis must be established following the American College of Rheumatology current clinical criteria as of the date of Your Disability.

Mental or Nervous Disorder or Disease means a medical condition which meets the diagnostic criteria set forth in the most recent edition of the Diagnostic And Statistical Manual Of Mental Disorders (“DSM”) as of the date of Your Disability.

Musculoskeletal means the bones, joints, joint capsules, cartilage, or adjacent tendons, ligaments or muscles.

Myelopathies means disease of the spinal cord supported by objective clinical findings of spinal cord pathology.

Myopathies means diseases of muscle fibers, supported by pathological findings on biopsy or electromyography (EMG).

Neurocognitive Disorder means a condition that meets the diagnostic criteria for neurocognitive disorders set forth in the most recent edition of the DSM as of the date of Your Disability, and the cognitive deficits that relate to the Disability are not attributable to another Mental or Nervous Disorder or Disease. Neurocognitive disorders include, but are not limited to, conditions such as Alzheimer’s disease and other forms of dementia, and Traumatic Brain Injury.

Neuromuscular means the peripheral motor nerves and the muscles that such nerves supply.

Related Disorders means conditions that are similar to Chronic Fatigue Syndrome in that the symptoms associated with the condition are comparable. These conditions include, but are not limited to, the following:

- Chronic Fatigue Immunodeficiency Syndrome;
- post Viral Syndrome, and
- Epstein-Barr virus infection.

The diagnosis must be established following the Center for Disease Control current clinical criteria as of the date of Your Disability.

DISABILITY INCOME INSURANCE: LIMITED DISABILITY BENEFITS (continued)

Repetitive Motion Disorders means muscular conditions that result from repeated motions performed in the course of normal work or daily activities and affecting upper or lower extremities.

Schizophrenia means a chronic psychiatric disorder diagnosed in accordance with the diagnostic criteria for Schizophrenia set forth in the most recent edition of the DSM as of the date of Your Disability.

Self-Reported Condition means the symptoms and other manifestations of Your condition that are not objectively verifiable using tests, procedures and clinical examinations that are standardly accepted in the practice of medicine. Self-Reported Conditions include, but are not limited to, conditions such as migraine and other types of headaches, symptoms of pain, fatigue, stiffness, soreness, ringing in ears, dizziness or vertigo, numbness, impaired concentration, and loss of energy.

Soft Tissue means the muscle, fat, fibrous tissues, and blood vessels, which connect, support, or surround the bony structures and organs of the body.

Spinal means components of the bony spine or spinal cord.

Spinal Cord Damage means injury or disease of the spinal cord with resultant paralysis.

Spinal Vascular Malformations means abnormal development of blood vessels within the spinal cord.

Tumor(s) means abnormal growths which may be malignant or benign.

DISABILITY INCOME INSURANCE: EXCLUSIONS

We will not pay for any Disability caused or contributed to by:

1. war, whether declared or undeclared, or act of war, or participation in an insurrection, rebellion, riot or terrorist act;
2. intentionally self-inflicted injury;
3. attempted suicide; or
4. commission of or attempt to commit or taking part in a felony.

FILING A DISABILITY INCOME INSURANCE CLAIM

The Policyholder should have a supply of claim forms. Obtain a claim form from the Policyholder and fill it out carefully. Return the completed claim form with the required Proof to the Policyholder.

If You are unable to report for Active Work due to a Sickness or accidental injury, and You think that You may be Disabled, You should contact MetLife or Your benefits representative to initiate a claim. We recommend that You do so no later than 30 days after the first day You are unable to report for Active Work so that Your claim can be processed in a timely manner.

When You file an initial claim for Disability Income Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 90 days after the end of the Elimination Period.

Notice of claim and Proof for Disability Income Insurance may also be given to Us by following the steps set forth below:

Step 1
You may give Us notice by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss.

Step 2
We will send a claim form to You and explain how to complete it. You should receive the claim form within 15 days of giving Us notice of claim.

Step 3
When You receive the claim form You should fill it out as instructed and return it with the required Proof described in the claim form. If You do not receive a claim form within 15 days after giving Us notice of claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

Step 4
You must give Us Proof not later than 90 days after the end of the Elimination Period.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given within 90 days after the end of the Elimination Period or if it is not reasonably possible to give notice of claim or Proof within such period, they are given as soon as is reasonably possible thereafter.

Items to be Submitted for a Disability Income Insurance Claim

When submitting Proof on an initial or continuing claim for Disability Income insurance, the following items may be required:

- documentation which must include, but is not limited to, the following information:
  - the date Your Disability started;
  - the cause of Your Disability;
  - the prognosis of Your Disability;
  - the continuity of Your Disability; and
  - Your application for:
    - Other Benefit Sources;
    - Federal Social Security disability benefits; and
    - Workers compensation benefits or benefits under a similar law.

FILING A DISABILITY INCOME INSURANCE CLAIM (continued)

- Written authorization for Us to obtain and release medical, employment and financial information and any other items We may reasonably require to document Your Disability or to determine Your receipt of or eligibility for Other Benefit Sources;
  - any and all medical information, including but not limited to:
    - x-ray films; and
    - photocopies of medical records, including:
      - histories,
      - physical, mental or diagnostic examinations; and
      - treatment notes; and
    - the names and addresses of all:
      - physicians and medical practitioners who have provided You with diagnosis, treatment or consultation;
      - hospitals or other medical facilities which have provided You with diagnosis, treatment or consultation;
      - pharmacies which have filled Your prescriptions within the past three years; and
  - additional proof elements as required and described within the additional plan provisions for which you are filing a claim for benefits.

Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

Disability Income Benefit Payments: Who We Will Pay

We will make any benefit payments during Your lifetime to You or Your legal representative as Beneficiary. Any payment made in good faith will discharge Us from liability to the extent of such payment.

Upon Your death, We will pay any amount that is or becomes due to Your designated Beneficiary. If there is no Beneficiary designated or no surviving designated Beneficiary at Your death, We may determine the Beneficiary for any amount that is or becomes due, according to the following order:

1. Your Spouse, if alive;
2. Your child(ren), if there is no surviving Spouse;
3. Your parent(s), if there is no surviving child(ren);
4. Your sibling(s), if there is no surviving parent(s);
5. Your estate, if there is no such surviving sibling(s).

If more than one person is eligible to receive payment, We will divide the benefit amount in equal shares.

Payment to a minor or incompetent will be made to such person's guardian. The term "children" or "child" includes natural and adopted children.

Any periodic payments owed to Your estate may be paid in a single sum.

Entire Contract

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

We will not use Your statements which relate to insurability to contest Disability Insurance after it has been in force for 2 years during Your life, unless the statement is fraudulent. In addition, We will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during Your life, unless the statement is fraudulent.

GENERAL PROVISIONS (continued)

Misstatement of Age

If Your age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

Conformity with Law

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

Physical Exams

If a claim is submitted for insurance benefits, We have the right to ask the insured to be examined by a Physician(s) of Our choice as often as is reasonably necessary to process the claim. We will pay the cost of such exam.

Autopsy

We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

Overpayments for Disability Income Insurance

Recovery of Overpayments

We have the right to recover any amount that We determine to be an overpayment.

An overpayment occurs if We determine that:

- the total amount paid by Us on Your claim is more than the total of the benefits due to You under this certificate; or
- payment We made should have been made by another group plan.

If such overpayment occurs, You have an obligation to reimburse Us. Our rights and Your obligations in this regard are described in the reimbursement agreement that You are required to sign when You submit a claim for benefits under this certificate. This agreement:

- confirms that You will reimburse Us for all overpayments; and
- authorizes Us to obtain any information relating to sources of Other Income.

How We Recover Overpayments

We may recover the overpayment from You by:

- stopping or reducing any future Disability benefits, including the Minimum Benefit, payable to You or any other payee under the Disability sections of this certificate;
- demanding an immediate refund of the overpayment from You; and
- taking legal action.

If the overpayment results from Our having made a payment to You that should have been made under another group plan, We may recover such overpayment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

GENERAL PROVISIONS (continued)

Lien and Repayment

If You become Disabled and You receive Disability benefits under this certificate and You receive payment from a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate (for example, a judgment, settlement, payment from Federal Social Security or payment pursuant to Workers' Compensation laws), You shall reimburse Us from the proceeds of such payment up to an amount equal to the benefits paid to You under this certificate for such Disability. Our right to receive reimbursement from any such proceeds shall be a claim or lien against such proceeds and Our right shall provide Us with a first priority claim or lien over any such proceeds up to the full amount of the benefits paid to You under this certificate for such Disability. You agree to take all action necessary to enable Us to exercise Our rights under this provision, including, without limitation:

- notifying Us as soon as possible of any payment You receive or are entitled to receive from a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate;

- furnishing of documents and other information as requested by Us or any person working on Our behalf; and

- holding in escrow, or causing Your legal representative to hold in escrow, any proceeds paid to You or any party by a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate, up to an amount equal to the benefits paid to You under this certificate for such Disability, to be paid immediately to Us upon Your receipt of said proceeds.

You shall cooperate and You shall cause Your legal representative to cooperate with Us in any recovery efforts and You shall not interfere with Our rights under this provision. Our rights under this provision apply whether or not You have been or will be fully compensated by a third party for any Disability for which You received or are entitled to receive benefits under this certificate.

THE PRECEDING PAGE IS THE END OF THE CERTIFICATE.
THE FOLLOWING IS ADDITIONAL INFORMATION.

SPECIAL SERVICES

Return To Work Program

Goal of Rehabilitation
The goal of MetLife is to focus on employees' abilities, instead of disabilities. This "abilities" philosophy is the foundation of our Return to Work Program. By focusing on what employees can do versus what they can't, we can assist you in returning to work sooner than expected.

Incentives For Returning To Work
Your Disability plan is designed to provide clear advantages and financial incentives for returning to work either full-time or part-time, while still receiving a Disability benefit. In addition to financial incentives, there may be personal benefits resulting from returning to work. Many employees experience higher self-esteem and the personal satisfaction of being self-sufficient and productive once again. If it is determined that you are capable, but you do not participate in the Return to Work Program, your Disability benefits may cease.

Return to Work Services
As a covered employee you are automatically eligible to participate in our Return to Work Program. The program aims to identify the necessary training and therapy that can help you return to work. In many cases, this means helping you return to your former occupation, although rehabilitation can also lead to a new occupation which is better suited to your condition and makes the most of your abilities.
There is no additional cost to you for the services we provide, and they are tailored to meet your individual needs. These services include, but are not limited to, the following:

1. **Vocational Analyses**

   Assessment and counseling to help determine how your skills and abilities can be applied to a new or a modified job with your employer.

2. **Labor Market Surveys**

   Studies to find jobs available in the national economy that would utilize your abilities and skills. Also identify your earning potential for a specific occupation.

3. **Retraining Programs**

   Programs to facilitate return to your previous job, or to train you for a new job.

4. **Job Modifications/Accommodations**

   Analyses of job demands and functions to determine what modifications may be made to maximize your employment opportunities.

   This also includes changes in your job or modifications to help you perform the previous job or a similar vocation.

5. **Job Seeking Skills and Job Placement Assistance**

   Special training to identify abilities, set goals, develop resumes, polish interviewing techniques, and provide other career search assistance.

Return to Work Program Staff
The Case Manager handling your claim will coordinate return to work services. You may be referred to a clinical specialist, such as a Nurse Consultant, Psychiatric Clinical Specialist, or Vocational Rehabilitation Consultant, who has advanced training and education to help people with disabilities return to work. One of our clinical specialists will work with you directly, as well as with local support services and resources. They have returned hundreds of individuals to meaningful, gainful employment.

SPECIAL SERVICES

Rehabilitation Vendor Specialists

In many situations, the services of independent vocational rehabilitation specialists may be utilized. Services are obtained at no additional cost to you; MetLife pays for all vendor services. Selecting a rehabilitation vendor is based on:

1. attending physician's evaluation and recommendations;
2. your individual vocational needs; and
3. vendor's credentials, specialty, reputation and experience.

When working with vendors, we continue to collaborate with you and your doctor to develop an appropriate return to work plan.

Social Security Assistance Program

If your claim for Disability benefits under this plan is approved, MetLife provides you with assistance in applying for Social Security disability benefits. Before outlining the details of this assistance, you should understand why applying for Social Security disability benefits is important.

Why You Should Apply For Social Security Disability Benefits

Both you and your employer contribute payroll taxes to Social Security. A portion of those tax dollars are used to finance Social Security's program of disability protection. Since your tax dollars help fund this program, it is in your best interest to apply for any benefits to which you may be entitled. Your spouse and children may also be eligible to receive Social Security disability benefits due to your Disability.

There are several reasons why it may be to your financial advantage to receive Social Security disability benefits. Some of them are:

1. Avoids Reduced Retirement Benefits

Should you become disabled and approved for Social Security disability benefits, Social Security will freeze your earnings record as of the date Social Security determines that your disability has begun. This means that the months/years that you are unable to work because of your disability will not be counted against you in figuring your average earnings for retirement and survivors benefit.

2. Medicare Protection

Once you have received 24 months of Social Security disability benefits, you will have Medicare protection for hospital expenses. You will also be eligible to apply for the medical insurance portion of Medicare.

3. Trial Work Period

Social Security provides a trial work period for the rehabilitation efforts of disabled workers who return to work while still disabled. Full benefit checks can continue for up to 9 months during the trial work period.

4. Cost-of-Living Increases Awarded by Social Security Will Not Reduce Your Disability Benefits

MetLife will not decrease your Disability benefit by the periodic cost-of-living increases awarded by Social Security. This is also true for any cost-of-living increases awarded by Social Security to your spouse and children.

This is called a Social Security "freeze." It means that only the Social Security benefit awarded to you and your dependents will be used by MetLife to reduce your Disability benefit; with the following exceptions:

a) an error by Social Security in computing the initial amount;

b) a change in dependent status; or

c) your Employer submitting updated earnings records to Social Security for earnings received prior to your Disability.

Over a period of years, the net effect of these cost-of-living increases can be substantial.

SPECIAL SERVICES

How MetLife Assists You in the Social Security Approval Process

As soon as you are approved for Disability benefits, MetLife begins assisting you with the Social Security approval process.

1. **Assistance Throughout the Application Process**

   MetLife has a dedicated team of Social Security Specialists. These Specialists, many of whom have worked for the Social Security Administration, are also located within our Claim Department. They provide expert assistance up front, offer support while you are completing the Social Security forms, and help guide you through the application process.

2. **Guidance Through Appeal Process by Social Security Specialists**

   Social Security disability benefits may be initially denied, but are often approved following an appeal. If your benefits are denied, our dedicated team of Social Security Specialists provides expert assistance on an appeal if your situation warrants continuing the appeal process. They guide you through each stage of the appeal process. These stages may include:

   a) Reconsideration by the Social Security Administration

   b) Hearing before an Administrative Law Judge

   c) Review by an Appeals Council established within the Social Security Administration in Washington, D.C.

   d) A civil suit in Federal Court.

3. **Social Security Attorneys**

   Depending on your individual needs, MetLife may provide a referral to an attorney who specializes in Social Security law. The Social Security approved attorney's fee is credited to the Long Term Disability overpayment, which results upon your receipt of the retroactive Social Security benefits. The attorney's fee, which is capped by Social Security law, will be deducted from the lump sum Social Security Disability benefits award and will not be used to further reduce your Long Term Disability benefit.

Early Intervention Program

The MetLife Early Intervention Program is offered to all covered employees, and your participation is voluntary*. The program helps identify early those employees who might benefit from vocational analyses and rehabilitation services before they are eligible for Long Term Disability benefits. Early rehabilitation efforts are more likely to reduce the length of your Long Term Disability and help you return to work sooner than expected.

If you cannot work, or can only work part-time due to a disability, your employer will notify MetLife. Our Clinical Specialists may be able to assist you by:

1. Reviewing and evaluating your disabling condition, even before a claim for Long Term Disability benefits is submitted (with your consent);
2. Designing individualized return to work plans that focus on your abilities, with the goal of return to work;
3. Identifying local community resources;
4. Coordinating services with other benefit providers, including: medical carrier, short term disability carrier,* workers' compensation carrier, and state disability plans;
5. Monitoring return to work plans in progress and modifying them as recommended by the attending physician (with your consent).
6. Providing analyses of job demands and functions to determine what modifications may be made to maximize your employment opportunities. It also includes an on-site ergonomic evaluation of work conditions to assist you in returning to work. If MetLife agrees that job modifications are likely to help you remain at work or return to work we may also agree (with your consent) to reimburse your employer for the cost of such modifications up to an amount agreed to between MetLife and your employer.

Our assistance is offered at no cost to either you or your employer.

* If you also have MetLife Short Term Disability coverage or Salary Continuance Plan Management, these services are provided automatically. Notification by your employer is not necessary.

Delaware American Life Insurance Company
MetLife Health Plans, Inc.
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.
Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

1.Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

2.Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

3.Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a legal plans company, and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

4.How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901, or by contacting MIB at www.mib.com.

5.Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what

products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

6.Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our “Using Your Information” section above

7.HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act (“HIPAA”) protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

8.Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

9.Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE CLUBCORP USA, INC. DISABILITY INSURANCE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

ERISA INFORMATION

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

ClubCorp USA, Inc.

3030 LBJ Freeway Suite 600

Dallas, TX 75234

972-888-7488

EMPLOYER IDENTIFICATION NUMBER: 75-2114856

PLAN NUMBER	COVERAGE	PLAN NAME
501	All Coverages	ClubCorp Health Benefits Plan, a Health and Welfare Benefit Plan

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

MetLife is liable for any benefits under the Plan. The group policy specifies the time when and the circumstances under which MetLife is liable for Disability Income Insurance: Long Term Benefits.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the rights to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event Your insurance ends in accordance with the DATE YOUR INSURANCE ENDS subsection of Your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife certificate.

CONTRIBUTIONS TO PREMIUM

If you enroll for Disability Income Insurance: Long Term Benefits coverage, you are required to make contributions to premiums.

Premium rates are set by MetLife.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 1st and ending on the following December 31st.

CLAIMS INFORMATION

Disability Benefits Claims

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Claim Submission

For claims for disability benefits, the claimant must report the claim to MetLife and, if requested, complete the appropriate claim form. The claimant must also submit the required proof as described in the "Filing A Claim" section of the certificate.

Claim forms requested by MetLife must be submitted in accordance with the instructions on the claim form.

Initial Determination

After you submit a claim for disability benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

FUTURE OF THE PLAN

It is hoped that This Plan will be continued indefinitely, but ClubCorp USA, Inc. reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of ClubCorp USA, Inc. shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.

Basic Life and AD&D – MetLife Plans

Invited provides Employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance through MetLife. This benefit is provided at no cost to you.

In the event of a death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your AD&D coverage may apply.

Plan Highlights	
Life and AD&D Benefit Amount	Hourly Employees: $10,000 Salaried Employees: $25,000
Accelerated Death Benefit	Included
Age Reduction	Benefits reduced by 35% at age 65 and 55% at age 70.
Portability	Included

The above information is a summary only. Please refer to your Certificate of Coverage for complete details of Plan benefits, limitations and exclusions.

View the full Life and AD&D Insurance Certificate by clicking **here**.

Beneficiary Designation

You **MUST** designate a beneficiary for your Life and AD&D insurance when you become eligible for coverage. Your beneficiary is the person (or people, estate, trust, etc.) who will receive your life insurance benefits if you pass away. If you do not name a beneficiary or if there are no surviving beneficiaries, in the event of your death, benefits will be paid to your estate.

You must elect a primary beneficiary (the first to receive benefits) and you may also elect a secondary beneficiary (if no surviving primary beneficiaries). Note: Texas is a community property state and if you designate someone other than your spouse as a beneficiary, your spouse must consent to such designation.

When naming minor children as beneficiaries, unless you have a clear will and/or estate plan in place that directs the court where and how your estate is treated in the event of your death, a minor cannot receive such payments and, in most cases, that benefit could be assigned to probate court for a judge to decide.

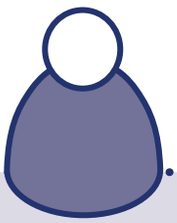
Situations often change, resulting in the need to update your beneficiary information. You should review and update this information every year, or prior to retirement.



Voluntary Life – MetLife Plans

Voluntary life insurance allows you to tailor coverage for your individual needs and provide financial protection for your beneficiaries in the event of your death.

Eligible Employees may purchase Voluntary Life insurance for themselves and their dependents. Premiums are paid through post-tax payroll deductions. Employees and dependents who elect coverage when first eligible can elect up to the Guaranteed Issue amount without being required to submit an Evidence of Insurability (EOI) form. If you elect more than the Guaranteed Issue amount or choose to waive coverage now and elect at a later date, you will be required to submit an EOI form.



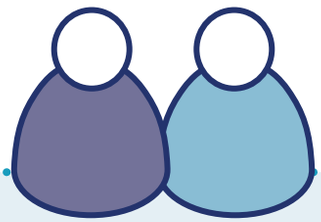
For You*

Increments of $10,000

Maximum: Lesser of $500,000 or 7 times annual salary

EOI required if:

1. Increasing more than two levels ($20,000) above the current coverage amount
2. Increasing any amount of above $380,000 (Guarantee Issue amount for newly eligible)



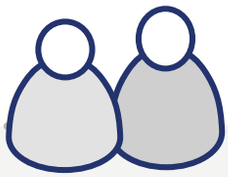
For Your Spouse*

Increments of $5,000

Maximum: Lesser of $100,000 or 50% of Employee amount.

EOI required if:

1. Increasing more than one level ($10,000) above the current coverage amount
2. Increasing any amount of above $30,000 (Guarantee Issue amount for newly eligible)



For Your Child

Increments of $5,000 up to $25,000

EOI not required

Accelerated Death Benefit and Portability features are included in the plan.

The above information is a summary only. Please refer to your Certificate of Coverage for complete details of Plan benefits, limitations and exclusions.

*If an Employee and/or Spouse did not elect coverage during the initial new hire enrollment period, and elects coverage at annual enrollment, then EOI is required for the entire coverage amount elected.

View the full Life and AD&D Insurance Certificate by clicking here.

View the Evidence of Insurability form by clicking here.

MetLife

Voluntary Accident – MetLife Plan

Accident insurance pays out a lump sum if you incur an injury as a result of an accident. These benefits may supplement both health and disability insurance, and can be used to pay for expenses that your health insurance doesn't cover or provide additional financial support if a covered event causes you to lose income due to being out of work.

Bi-Weekly Rates	
Employee Only	$4.26
Employee and Spouse	$8.52
Employee and Child(ren)	$10.36
Employee and Family	$12.20

Benefits	Amount
Fractures	**If more than one bone is fractured; max benefit is no more than 2x highest fracture benefit**
Face or Nose	$2,000
Jaw	Lower Mandible $1,000, Upper Maxilla $2,000
Arm	Upper Arm $2,000, Shoulder Blade, Collarbone, Forearm, Hand, Wrist (except fingers) $1,000
Vertebrae	$4,000
Pelvis	$4,000
Hip, Thigh (femur)	$8,000
Leg (tibia and/or fibula)	$4,000
Chip Fracture	25%
Dislocations	**If more than one joint is dislocated, the amount we will pay for all dislocations combined will be no more than 2 times the highest dislocation benefit**
Lower Jaw	Closed $1,000, Open $2,000
Collarbone	Closed $1,500, Open $3,000
Shoulder	Closed $1,000, Open $2,000
Rib	Closed $1,000, Open $2,000
Elbow	Closed $1,000, Open $2,000
Wrist & Bones of the Hand	Closed $1,000, Open $2,000
Hip	Closed $4,000, Open $8,000
Partial Dislocation	25%
Burn Benefit	**1 time per accident; unlimited time(s) per calendar year**
2nd Degree 10-25% surface skin burnt	$200
2nd Degree 25-35% surface skin burnt	$750
2nd Degree 35% or more of surface skin burnt	$1,500
3rd Degree w/ less than 10% of surface skin burnt	$1,500
3rd Degree 10-25% surface skin burnt	$2,000
3rd Degree 25-35% surface skin burnt	$7,000
3rd Degree 35% or more of surface skin burnt	$12,000
Medical Treatment and Services	
Ground Ambulance	$400; 1 time per accident; unlimited time(s) per calendar year
Air Ambulance	$1,200; 1 time per accident; unlimited time(s) per calendar year
Emergency Room	$200
Urgent Care	$100
Physician's Office	$100
Blood/Plasma/Platelets	$500
Hospital Admission Benefit	$1000; additional $1,000 for ICU admission 1 time per accident; unlimited time(s) per calendar year
Health Screening Benefit	**$100 1 time per calendar year for all enrolled. Pays IF you have your annual wellness visit.**

View the Accident Insurance Certificate by clicking **here**.

ACCIDENT PLAN 1

METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK

ORGANIZED SPORTS ACTIVITY INJURY BENEFIT CERTIFICATE RIDER

Group Policy No.: 0119217

Policyholder: ClubCorp USA, Inc.

Rider Effective Date: THE LATER OF JANUARY 1, 2023 OR THE CERTIFICATE EFFECTIVE DATE

This Rider is added to Your Certificate of Accident Insurance.

DEFINITIONS

Organized Sports Activity means an amateur sports competition or organized practice for an amateur sports competition:

- in which participation is not for wage or profit;
- which is overseen by an Amateur Sports Organization; and
- in which formal registration is required to participate.

The term Organized Sports Activity does not include:

- coaching, officiating or refereeing activities;
- travel to or from a sports competition or practice; or
- any activities that occur before, after or between sports competitions or practices.

Amateur Sports Organization means an organization that oversees scholastic, recreational or social sports activities, sets up official rules and standards of play, arranges for officials to oversee competition, and organizes inter-team competition, facilities and equipment. The term includes public and private schools and sports associations.

ORGANIZED SPORTS ACTIVITY INJURY BENEFIT

If any of the benefits listed under Benefits Eligible for Organized Sports Activity Injury Benefit section of this Rider are payable under the Certificate for an Injury sustained by a Covered Person, We will increase the amount(s) payable under the Certificate for such benefit(s) by 25% if the following requirements are met:

- the Injury resulted from an Accident that occurred while such Covered Person was participating as a player in an Organized Sports Activity;
- We are provided with Proof of such Covered Person's registration for participation in the Organized Sports Activity; and
- We are provided with any incident report in which the Accident is reported or information that supports that the Accident occurred during an Organized Sports Activity.

LIMITATIONS

The Organized Sports Activity Injury Benefit is only payable as an increase to a benefit that is payable under the Certificate for an Injury. If a particular benefit is not payable under the Certificate for the Injury, no increased amount will be payable under this Rider for such benefit.

BENEFITS ELIGIBLE FOR ORGANIZED SPORTS ACTIVITY INJURY BENEFIT

Accidental Injury Benefits
Accident – Medical Treatment and Services Benefits
Hospital Benefits

WHEN THIS RIDER ENDS

This Rider will end if insurance under the Certificate ends in accordance with the When Insurance Ends provision of the Certificate, however, this Rider will continue if Your insurance is continued under the Continuation of Insurance section of the Certificate.

Timothy J. Ring
Secretary

Michel Khalaf
President & CEO

This Rider is to be attached to and made a part of Your Certificate.

METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK

CERTIFICATE OF ACCIDENT INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this Certificate, subject to the provisions of this Certificate. References to coverage for Your Dependents throughout this Certificate only apply if insurance is in effect for Your Dependents. Please refer to the Covered Person Specifications page and Eligibility Provisions: Dependent Insurance section for details.

This Certificate is issued to You under the Group Policy. This Certificate includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.** The Group Policy is a contract between MetLife and the Group Policyholder. It may be changed or ended without Your consent or notice to You.

Group Policyholder:	ClubCorp USA, Inc.
Group Policy Number:	0119217
MetLife Toll Free Number:	1-800-GETMET8

Important Notice: The insurance evidenced by this Certificate provides limited benefits. Subject to its terms, conditions and limitations, this Certificate provides benefits for Accidental Injuries. The benefit amounts are shown in the Schedule and are not based on any medical expenses that are incurred. You should have medical coverage in force when You enroll for this insurance.

This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with Your taxes.

30-Day Right to Examine Certificate. Please read this Certificate carefully. If You are not satisfied for any reason, You may notify Us that You are cancelling Your Certificate within 30 days from the date of delivery by calling Us at 1-800-GETMET8. If You notify Us that You are cancelling within the 30 day period, this Certificate will be void from the beginning. We will refund any premium or Contribution paid within 30 days after We receive Your notice of cancellation.

Maryland Residents: The Group Policy providing coverage under this Certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

Have a complaint or need help?

If You have a problem with a claim or Your premium, call Your insurance company or HMO first. If You can't work out the issue, the Texas Department of Insurance may be able to help.

Even if You file a complaint with the Texas Department of Insurance, You should also file a complaint or appeal through Your insurance company or HMO. If You don't, You may lose Your right to appeal.

Metropolitan Life Insurance Company

To get information or file a complaint with Your insurance company or HMO:

Call: Corporate Consumer Relations Department at 1-800-438-6388

Toll-free: 1-800-438-6388

Email: Johnstown_Complaint_Referrals@metlife.com

Mail: Metropolitan Life Insurance Company
700 Quaker Lane, 2nd Floor
Warwick, Rhode Island 02886

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Metropolitan Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388

Teléfono gratuito: 1-800-438-6388

Correo electrónico: Johnstown_Complaint_Referrals@metlife.com

Dirección postal: Metropolitan Life Insurance Company
700 Quaker Lane, 2nd Floor
Warwick, Rhode Island 02886

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

NOTICE FOR RESIDENTS OF MAINE

If You were a resident of Maine on Your Certificate effective date, this notice applies to You.

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as non-payment of a Contribution that is due. You may make this designation by completing a "Third Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this Certificate to obtain a Third Party Notice Request Form.

Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf, or any covered Dependent may request reinstatement of the Certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

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COVERED PERSON SPECIFICATIONS

Certificate Effective Date:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Group Policyholder:	ClubCorp USA, Inc.
Group Policy Number:	0119217
MetLife Contact Information:	1-800-GETMET8
Your Name:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Your Certificate Number:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Coverage for Your Dependents	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife

This Covered Person Specifications page is part of Your Certificate. Please keep it with Your Certificate.

SCHEDULE OF INSURANCE

IMPORTANT NOTE: Payment of the benefits listed in this Schedule is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate. PLEASE READ THE ENTIRE CERTIFICATE CAREFULLY.

The listing of benefits for Dependents only applies if insurance is in effect for Your Dependents under this Certificate. Please refer to the Covered Person Specifications page and the Eligibility Provisions: Dependent Insurance section of this Certificate for details.

PARALYSIS BENEFIT:	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
Two limbs (paraplegia or hemiplegia)	$20,000	$20,000	$20,000
Four limbs (quadriplegia)	$40,000	$40,000	$40,000

ACCIDENTAL INJURY BENEFITS:

Fracture Benefit*	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
Fracture Benefit For Closed Reduction:			
Face or Nose (except mandible or maxilla)	$2,000	$2,000	$2,000
Skull fracture – depressed (except bones of face or nose)	$4,000	$4,000	$4,000
Skull fracture – non-depressed (except bones of face or nose)	$2,000	$2,000	$2,000
Lower Jaw, Mandible (except alveolar process)	$1,000	$1,000	$1,000
Upper Jaw, Maxilla (except alveolar process)	$2,000	$2,000	$2,000
Upper Arm between Elbow and Shoulder (humerus)	$2,000	$2,000	$2,000
Shoulder Blade (scapula), Collarbone (clavicle, sternum)	$1,000	$1,000	$1,000
Forearm (radius and/or ulna), Hand, Wrist (except fingers)	$1,000	$1,000	$1,000
Rib	$1,000	$1,000	$1,000
Finger, Toe	$200	$200	$200
Vertebrae, Body of (excluding vertebral processes)	$2,000	$2,000	$2,000
Vertebral Processes	$750	$750	$750
Pelvis (includes ilium, ischium, pubis, acetabulum except coccyx)	$2,000	$2,000	$2,000
Hip, Thigh (femur)	$4,000	$4,000	$4,000
Coccyx	$750	$750	$750
Leg (tibia and/or fibula)	$2,000	$2,000	$2,000
Kneecap (patella)	$750	$750	$750
Ankle	$750	$750	$750
Foot (except toes)	$750	$750	$750

SCHEDULE OF INSURANCE (Continued)

	For You	For Your Spouse	For Your Dependent Child(ren)
Fracture Benefit For Open Reduction:			
Face or Nose (except mandible or maxilla)	$4,000	$4,000	$4,000
Skull fracture – depressed (except bones of face or nose)	$8,000	$8,000	$8,000
Skull fracture – non-depressed (except bones of face or nose)	$4,000	$4,000	$4,000
Lower Jaw, Mandible (except alveolar process)	$2,000	$2,000	$2,000
Upper Jaw, Maxilla (except alveolar process)	$4,000	$4,000	$4,000
Upper Arm between Elbow and Shoulder (humerus)	$4,000	$4,000	$4,000
Shoulder Blade (scapula), Collarbone (clavicle, sternum)	$2,000	$2,000	$2,000
Forearm (radius and/or ulna), Hand, Wrist (except fingers)	$2,000	$2,000	$2,000
Rib	$2,000	$2,000	$2,000
Finger, Toe	$400	$400	$400
Vertebrae, Body of (excluding vertebral processes)	$4,000	$4,000	$4,000
Vertebral Processes	$1,500	$1,500	$1,500
Pelvis (includes ilium, ischium, pubis, acetabulum except coccyx)	$4,000	$4,000	$4,000
Hip, Thigh (femur)	$8,000	$8,000	$8,000
Coccyx	$1,500	$1,500	$1,500
Leg (tibia and/or fibula)	$4,000	$4,000	$4,000
Kneecap (patella)	$1,500	$1,500	$1,500
Ankle	$1,500	$1,500	$1,500
Foot (except toes)	$1,500	$1,500	$1,500

***Chip Fracture Benefit** for any of the above: Benefit is 25% of the applicable benefit for the bone involved.

Dislocation Benefit*	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
Full Dislocation Benefit for Closed Reduction:			
Lower Jaw	$1,000	$1,000	$1,000
Collarbone (sternoclavicular)	$1,500	$1,500	$1,500
Collarbone (acromioclavicular and separation)	$1,000	$1,000	$1,000
Shoulder (glenohumeral)	$1,000	$1,000	$1,000
Rib	$1,000	$1,000	$1,000
Elbow	$1,000	$1,000	$1,000
Wrist	$1,000	$1,000	$1,000
Bone or Bones of the Hand (other than fingers)	$1,000	$1,000	$1,000
Hip	$4,000	$4,000	$4,000
Knee (except patella)	$2,000	$2,000	$2,000
Ankle - Bone or Bones of the Foot (other than toes)	$1,000	$1,000	$1,000
One Toe or Finger	$200	$200	$200

	For You	**For Your Spouse**	**For Your Dependent Child(ren)**
Full Dislocation Benefit for Open Reduction:			
Lower Jaw	$2,000	$2,000	$2,000

SCHEDULE OF INSURANCE (Continued)

Collarbone (sternoclavicular)	$3,000	$3,000	$3,000
Collarbone (acromioclavicular and separation)	$2,000	$2,000	$2,000
Shoulder (glenohumeral)	$2,000	$2,000	$2,000
Rib	$2,000	$2,000	$2,000
Elbow	$2,000	$2,000	$2,000
Wrist	$2,000	$2,000	$2,000
Bone or Bones of the Hand (other than fingers)	$2,000	$2,000	$2,000
Hip	$8,000	$8,000	$8,000
Knee (except patella)	$4,000	$4,000	$4,000
Ankle - Bone or Bones of the Foot (other than toes)	$2,000	$2,000	$2,000
One Toe or Finger	$400	$400	$400

***Partial Dislocation Benefit** for any of the above: Benefit is 25% of the applicable benefit for joint involved.

Burn Benefit: **Benefit for 2nd Degree Burn** **Percentage of total surface skin area that is burnt**	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
Less than 10%	$100	$100	$100
At least 10% but less than 25%	$200	$200	$200
At least 25% but less than 35%	$750	$750	$750
35% or more	$1,500	$1,500	$1,500

Burn Benefit: **Benefit for 3rd Degree Burn** **Percentage of total surface skin area that is burnt**	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
Less than 10%	$1,500	$1,500	$1,500
At least 10% but less than 25%	$2,000	$2,000	$2,000
At least 25% but less than 35%	$7,000	$7,000	$7,000
35% or more	$12,000	$12,000	$12,000

Concussion Benefit	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
	$500	$500	$500

Coma Benefit	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
	$10,000	$10,000	$10,000

Laceration Benefit:	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
Repaired without stitches	$75	$75	$75
Repaired with stitches			
Total of all lacerations is less than two inches (5.08 cm) long	$125	$125	$125
Total of all lacerations is two to six inches (5.08 to 15.24 cm) long	$350	$350	$350
Total of all lacerations is over six inches (over 15.24 cm) long	$700	$700	$700

SCHEDULE OF INSURANCE (Continued)

Broken Tooth Benefit:	For You	For Your Spouse	For Your Dependent Child(ren)
Crown	$300	$300	$300
Extraction	$150	$150	$150
Filling	$50	$50	$50

Eye Injury Benefit	For You	For Your Spouse	For Your Dependent Child(ren)
	$300	$300	$300

ACCIDENT - MEDICAL TREATMENT AND SERVICES BENEFITS

Air Ambulance Benefit	For You	For Your Spouse	For Your Dependent Child(ren)
	$1,200	$1,200	$1,200

Ground Ambulance Benefit	For You	For Your Spouse	For Your Dependent Child(ren)
	$400	$400	$400

Emergency Care Benefit	For You	For Your Spouse	For Your Dependent Child(ren)
Emergency Room	$200	$200	$200
Physician's Office	$100	$100	$100
Urgent Care	$100	$100	$100

Non-Emergency Initial Care Benefit	For You	For Your Spouse	For Your Dependent Child(ren)
	$100	$100	$100

Medical Testing Benefit	For You	For Your Spouse	For Your Dependent Child(ren)
	$200	$200	$200

SCHEDULE OF INSURANCE (Continued)

Physician Follow-Up Visit Benefit	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
	$100	$100	$100

Transportation Benefit	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
	$400	$400	$400

Therapy Services Benefit:	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
Cognitive behavioral therapy	$50	$50	$50
Occupational therapy	$50	$50	$50
Physical therapy	$50	$50	$50
Respiratory therapy	$50	$50	$50
Speech therapy	$50	$50	$50
Vocational therapy	$50	$50	$50
Acupuncture	$50	$50	$50
Chiropractic therapy	$50	$50	$50

Pain Management Benefit (for Epidural Anesthesia)	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
	$100	$100	$100

Prosthetic Device Benefit	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
One device only	$1,000	$1,000	$1,000
More than one device	$2,000	$2,000	$2,000

Medical Appliance Benefit:	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
Brace	$150	$150	$150
Cane	$150	$150	$150
Crutches	$150	$150	$150
Walker – expected use less than 1 year	$200	$200	$200
Walker – expected use 1 year or longer	$400	$400	$400
Walking boot	$150	$150	$150
Wheel chair or motorized scooter – expected use less than 1 year	$300	$300	$300
Wheel chair or motorized scooter – expected use 1 year or longer	$1,000	$1,000	$1,000
Other medical device used for mobility	$150	$150	$150
Medical Appliance Benefit Limit: Limit for all Medical Appliances combined, per Covered Person, per Accident	$1,000	$1,000	$1,000

Modification Benefit	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
	$1,500	$1,500	$1,500

Blood/Plasma/Platelets Benefit	**For You**	**For Your Spouse**	**For Your Dependent**

			Child(ren)
	$500	$500	$500

SCHEDULE OF INSURANCE (Continued)

Surgery Benefits:	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
Surgical Repair Benefit:			
Cranial	$2,000	$2,000	$2,000
Hernia	$200	$200	$200
Ruptured Disc	$1,500	$1,500	$1,500
Skin Graft Benefit (only payable for a burn for which the Burn Benefit was paid)	50% of the Burn Benefit that was paid	50% of the Burn Benefit that was paid	50% of the Burn Benefit that was paid
Torn cartilage in knee	$1,500	$1,500	$1,500
Torn, ruptured or severed tendon/ligament/rotator cuff			
One tendon/ligament/rotator cuff	$1,000	$1,000	$1,000
Two or more tendons/ligaments/rotator cuffs	$2,000	$2,000	$2,000
Thoracic cavity or abdominal pelvic cavity	$2,000	$2,000	$2,000
Exploratory Surgery Benefit for any of the procedures listed above	$200	$200	$200

Other Outpatient Surgery Benefit	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
	$400	$400	$400

ACCIDENT - HOSPITAL BENEFITS

Admission Benefit (for the day of admission)	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
	$1,000	$1,000	$1,000

ICU Supplemental Admission Benefit (for the day of admission)	**For You**	**For Your Spouse**	**For Your Dependent Child(ren)**
	$1,000	$1,000	$1,000

SCHEDULE OF INSURANCE (Continued)

Confinement Benefit	For You	For Your Spouse	For Your Dependent Child(ren)
	$300 per day	$300 per day	$300 per day

ICU Supplemental Confinement Benefit	For You	For Your Spouse	For Your Dependent Child(ren)
	$300 per day	$300 per day	$300 per day

Inpatient Rehabilitation Benefit	For You	For Your Spouse	For Your Dependent Child(ren)
	$200 per day	$200 per day	$200 per day

OTHER BENEFITS

Health Screening Benefit	For You	For Your Spouse	For Your Dependent Child(ren)
	$100	$100	$100

Lodging Benefit	For You	For Your Spouse	For Your Dependent Child(ren)
	$200 per day	$200 per day	$200 per day

DEFINITIONS

As used in this Certificate, the terms listed below will have the meanings set forth below. Other terms may be defined where they are used. When defined terms are used in this Certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Accident means an act or event which:
- is unforeseen, unexpected and unanticipated;
- is definite as to time and place;
- is not a Sickness; and
- occurs while insurance is in effect under this Certificate.

The term Accident includes unavoidable exposure to the elements if such exposure was a direct result of an Accident.

Accidental or **Accidentally** means happening by Accident.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:
- the Group Policyholder's place of business;
- an alternate place approved by the Group Policyholder; or
- a place to which the Group Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Group Policyholder approved vacations, holidays or temporary business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Certificate means this Certificate including any riders attached to it.

Coma means a continuous state of profound unconsciousness lasting for a period of 14 or more consecutive days, characterized by the absence of purposeful response to commands, including:
- eye opening;
- verbal response; and
- motor response.

Confined or Confinement means the assignment to a bed as a resident inpatient in a Hospital (including an Intensive Care Unit of a Hospital) on the advice of a Physician or confinement in an observation area within a Hospital for a period of no less than 20 continuous hours on the advice of a Physician.

Contribution means the amount You must pay towards the total premium charged by Us for insurance under this Certificate.

Covered Person means You and, if insured under the Group Policy for the insurance described in this Certificate, Your Dependents.

Covered Surgery means any of the following procedures:
- cranial Surgery;
- skin graft to treat a burn for which the Burn Benefit was paid;
- Surgery to treat a hernia;
- thoracic cavity and abdominal pelvic cavity Surgery;
- Surgery to treat a Ruptured Disc;
- Surgery to treat torn cartilage in the knee (meniscus); or
- Surgery to treat a torn, ruptured or severed tendon, ligament or rotator cuff.

DEFINITIONS (Continued)

Dependent means Your Spouse, and/or Dependent Child. No person can be insured for Accident Insurance under the Group Policy as both an employee and a Dependent.

Dependent Child means the following:
- Your biological child, while such child is younger than the Dependent Child Age Limit;
- Your adopted child, while such child is younger than the Dependent Child Age Limit;
- Your stepchild, while such child is younger than the Dependent Child Age Limit;
- Your grandchild, while such child is younger than the Dependent Child Age Limit and who was able to be claimed by You as a dependent for Federal Income Tax purposes at the time You enrolled such grandchild; or
- a child for whom You must provide medical support under an order: issued under Texas Statutes, Chapter 154, Family Code; or enforceable by a court in the State of Texas.

The term Dependent Child does not mean an unborn or stillborn child.

A person cannot be insured for Accident Insurance as a Dependent Child of more than one employee under the Group Policy.

Dependent Child Age Limit means:
- the end of the calendar month in which the Dependent Child reaches age 26.

Dependent Insurance means insurance under this Certificate for Your Dependents.

Dismemberment means any of the following:

- Loss of an arm: the arm is permanently severed at or above the elbow.
- Loss of a hand: the hand is permanently severed at or above the wrist joint.
- Loss of a finger: the finger is permanently severed at the joint proximate to the first interphalangeal joint where it is attached to the hand.
- Loss of a foot: the foot is permanently severed at or above the ankle joint.
- Loss of a leg: the leg is permanently severed at or above the knee.
- Loss of a toe: the toe is permanently severed at the joint proximate to the first interphalangeal joint where it is attached to the foot.

Emergency Room means an area within a Hospital that is dedicated to the provision of emergency care. This area must:
- be staffed and equipped to handle trauma;
- be supervised and provide treatment by Physicians; and
- provide care seven days per week, 24 hours per day.

Full-Time means Active Work on the Group Policyholder's regular work schedule for the class of employees to which You belong. The work schedule must be at least 30 hours per week.

Group Policy means the policy of insurance issued by Us to the Group Policyholder under which this Certificate is issued.

Group Policyholder means ClubCorp USA, Inc..

Hospital means a short-term, acute care, general facility which:
- is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine;
- has facilities for major Surgery either on its premises or through contractual arrangement with another Hospital;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

Injury means any bodily harm:
- that results directly from an Accident; and
- is not specifically excluded as set forth in the section titled Accident - Exclusions.

Intensive Care Unit or **ICU** means a place which:
- is a specifically dedicated area of a Hospital that is restricted to patients who are critically ill or injured and who require intensive, comprehensive monitoring and care;
- is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- is under close observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis; and
- has a Physician assigned to the intensive care unit on a full-time basis.

The term Intensive Care Unit includes Hospital units with the following names: Intensive Care Unit; Coronary Care Unit; Neonatal Intensive Care Unit; Pulmonary Care Unit; Burn Unit; or Transplant Unit.

Medical Restriction means a person is:
- restricted to the person's home under a Physician's care;
- receiving or applying to receive disability benefits from any source;
- an inpatient in a Hospital;
- receiving care in a hospice facility, an intermediate care facility or a long-term care facility; or
- receiving chemotherapy, radiation therapy or dialysis.

Other Outpatient Surgery means Surgery performed on an outpatient basis, other than a Surgery for which the Surgery Benefit is payable.

Outpatient Surgery Facility means a facility mainly engaged in performing outpatient Surgery. It must:
- be accredited as an ambulatory surgery facility by either the Joint Commission or the Accreditation Association for Ambulatory Care;
- be approved as an ambulatory Surgery facility by Medicare; or
- meet all of the following criteria:
  - maintains all appropriate licensing for a facility that provides ambulatory Surgery;
  - is staffed by Physicians and nurses, under the supervision of a Physician;
  - has permanent operating and recovery rooms;
  - is staffed and equipped to provide emergency care; and
  - has written back-up arrangements with a local Hospital for emergency care.

Physician means:
- a person licensed to practice medicine and prescribe and administer drugs or to perform Surgery in the jurisdiction where such services are performed; or
- a medical practitioner who is licensed to provide a service for which a benefit is payable under this Certificate, according to the laws and regulations of the jurisdiction where such service is performed, and who is acting within the scope of such license.

The term Physician (for other than a dentist) does not include:
- You;
- Your Spouse or anyone to whom You are related by blood or marriage;
- anyone with whom You are residing;
- Your adopted or stepchild;
- anyone with whom You share a business interest; or
- Your employee.

Primary Residence means the dwelling where a person lives for the majority of the time, whether the person owns or rents the dwelling.

Proof means Written evidence satisfactory to Us that a claimant has satisfied the conditions and requirements for any benefit described in this Certificate. When a claim is made for any benefit described in this Certificate, Proof must establish:
- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Except as provided in the Examinations and Autopsy provisions of this Certificate, Proof must be provided at the claimant's expense.

Rehabilitation Facility means a facility that:
- provides rehabilitation care services on an inpatient basis; and
- maintains all required licenses and certifications.

Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by an Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians.

The term Rehabilitation Facility does not include:
- a nursing home;
- an extended care facility, unless the Covered Person is receiving rehabilitation care services on an inpatient basis at the extended care facility;
- a Skilled Nursing Facility, unless the Covered Person is receiving rehabilitation care services on an inpatient basis at the facility;
- a rest home or home for the aged;
- a hospice care facility;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

Ruptured Disc means a tear in the spinal disc capsule. It does not include a bulging disc.

Schedule means the Schedule of Insurance that appears in this Certificate, and the Covered Person Specifications page.

Sickness means:
- a physical illness, physical infirmity or physical disease;
- pregnancy; or
- infection, but not an infection received through an Accidental cut or wound.

Signed means any method executed or adopted by a person with the present intention to authenticate a record. The signature may be transmitted by paper or electronic media, provided it is consistent with applicable law.

Skilled Nursing Facility means a facility that provides skilled, intermediate or custodial care that meets all of the following requirements:
- if licensing or certification is required, maintains all appropriate licensing or certification under the laws where it is located as a skilled or intermediate nursing facility;
- has 24 hour a day nursing care provided by any of the following who is licensed under the laws where the services are performed: a registered professional nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.);
- has 24 hour a day care performed by an awake, and trained or certified staff supervised by a nurse who is an R.N, L.P.N. or L.V.N.;
- keeps a Written record of services performed for each client;
- has established procedures to obtain emergency medical care; and
- services are not limited to provision of food, shelter, and other residential services such as laundry.

Spouse means Your lawful spouse.

Surgery means a procedure performed by a Physician involving an incision of the Covered Person's skin or tissue that, in and of itself, is intended to be curative, palliative or exploratory.

Urgent Care Facility means a health care facility:

- that is separate from a Hospital or a separate unit within a Hospital; and
- the primary purpose of which is the offering and provision of immediate, short-term medical care, for urgent care.

United States means the United States of America, its territories and its possessions.

We, Us and **Our** mean Metropolitan Life Insurance Company.

Write, Written or **Writing** means a record that may be transmitted by paper or electronic media, and that is consistent with applicable law.

You and **Your** means an employee who is insured under the Group Policy for the insurance described in this Certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS

CLASS 1

All Active Full-Time Employees

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the Accident Insurance available for Your eligible class.

If You are in an eligible class on the date insurance becomes available for the class, You will be eligible for insurance on the date You complete any applicable eligibility waiting period set by the Group Policyholder.

If you enter an eligible class after the date insurance becomes available to members of that class, You will be eligible for insurance on the date You complete any applicable eligibility waiting period set by the Group Policyholder.

ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the required form. You must also provide Written permission to deduct Contributions from Your pay for such insurance, if You are required to make such Contributions.

DATE YOUR INSURANCE TAKES EFFECT

Provided that You are Actively at Work in an eligible class, insurance under this Certificate will take effect for You on the Certificate effective date. If You are not Actively at Work in an eligible class on the date insurance would otherwise take effect, insurance will take effect on the date You return to Active Work in an eligible class.

BENEFIT CHANGES

Once Your insurance takes effect, You may only change Your benefits in accordance with the options available through the Group Policyholder. Please contact Us or the Group Policyholder for more information.

If You are not Actively at Work in an eligible class on the date an increase in benefits would otherwise take effect, the increase will not take effect until You return to Active Work in a class that is eligible for the increase.

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE

ELIGIBLE CLASS FOR DEPENDENT INSURANCE

All Class 1 employees of the Group Policyholder as specified in the Eligibility Provisions: Insurance For You section of this Certificate are eligible for Dependent Insurance.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

If You are in a class of employees who are eligible for Dependent Insurance on the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date Your insurance takes effect; and
- the date an individual becomes Your first Dependent.

If You enter a class of employees who are eligible for Dependent Insurance after the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date You enter a class eligible for Dependent Insurance; and
- the date an individual becomes Your first Dependent.

ENROLLMENT PROCESS

If You become eligible for Dependent Insurance, You may enroll for such insurance by providing Us with any information We require for each Dependent to be insured. You must also provide Written permission to deduct Contributions from Your pay for Dependent Insurance, if You are required to make such Contributions.

DATE DEPENDENT INSURANCE TAKES EFFECT

Newborn Children

A Dependent Child born to You while insurance is in effect under the Certificate will be covered:

- from the moment of birth and does not need to be enrolled if Dependent Insurance is already in effect for at least one other Dependent Child; or
- for 31 days from the moment of birth if Dependent Insurance is not already in effect for at least one other Dependent Child. To continue coverage beyond the first 31 days You must notify Us of the child's birth and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the newborn child.

The effective date of insurance for a newborn child will be determined without regard to whether the child is under a Medical Restriction.

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE (Continued)

Adopted Children

A Dependent Child adopted by You or Placed for Adoption with You while insurance is in effect under the Certificate will be covered:

- from the moment of birth if Placement for Adoption or adoption occurs within 31 days after the child's birth; or
- from the date of adoption or Placement for Adoption if the child is adopted by You or Placed for Adoption with You more than 31 days after the child's birth.

The child does not need to be enrolled if Dependent Coverage is already in effect for at least one other Dependent Child. If Dependent Coverage is not already in effect for at least one other Dependent Child, then to continue the child's coverage beyond the first 31 days of coverage, You must notify Us of the child's adoption or Placement for Adoption and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the adopted child. You must do this within 31 days of the date the child is adopted by You or Placed for Adoption with You.

The effective date of insurance for a newly adopted child will be determined without regard to whether the child is under a Medical Restriction.

Placed for Adoption or **Placement for Adoption** means:

- the assumption and retention by You of a legal obligation for total or partial support of a child in anticipation of Your adoption of the child; or
- that there is a suit to which You are a party, in which You seek to adopt the child.

A Child Covered Pursuant to a Medical Support Order

A child for whom You are required to provide insurance pursuant to a medical support order issued under Texas Statutes Chapter 154, Family Code; or enforceable by a court in the State of Texas, that is entered while insurance is in effect under the Certificate will be covered from the date specified in the order.

The child does not need to be enrolled if Dependent Coverage is already in effect for at least one other Dependent Child. If Dependent Coverage is not already in effect for at least one other Dependent Child, then to continue the child's coverage beyond the first 31 days of coverage, You must notify Us of Your obligation to cover the child and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the child. You must do this within 31 days of the date You become obligated to cover the child.

The effective date of insurance for a child who becomes covered under this Certificate pursuant to a medical support order while this insurance is in effect under the Certificate will be determined without regard to whether the child is under a Medical Restriction.

Other Dependents

Dependent Insurance for a Dependent who is not under a Medical Restriction will take effect on the later of:

- the date You are enrolled for Dependent Insurance for such Dependent; or
- the date a person becomes Your Dependent.

If a Dependent is under a Medical Restriction on the date insurance for such Dependent would otherwise take effect, insurance for the Dependent will take effect on the date the Dependent is no longer under a Medical Restriction.

PARALYSIS BENEFITS

Payment of the Paralysis Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

PARALYSIS BENEFIT

If a Covered Person sustains an Injury that is Paralysis, We will pay the Paralysis Benefit shown in the Schedule that applies to the type of Paralysis that the Covered Person sustained, subject to all of the following:

- Paralysis must be documented by a Physician within 180 days after the Accident occurs.
- If a Covered Person sustains an Injury that is Paralysis that falls under more than one classification on the Schedule, We will only pay the benefit that applies to the classification that pays the highest benefit.
- We will pay the Paralysis Benefit no more than one time per Covered Person, per Accident.

Paralysis means the permanent total and irrecoverable loss of movement of 2 or more limbs:

- that has lasted for a continuous period of not less than 90 days as confirmed by a Physician; or
- as a result of transected spinal cord with supporting clinical and radiological evidence and no expectation of return to function.

The term Paralysis does not include a Dismemberment or Coma.

ACCIDENTAL INJURY BENEFITS

Payment of the Accidental Injury Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

FRACTURE BENEFIT

If a Covered Person sustains an Injury that is a Fracture, We will pay the Fracture Benefit, shown in the Schedule that is applicable to the type of Fracture sustained by the Covered Person, subject to all of the following:

- The Injury must be diagnosed and treated as a Fracture by a Physician within 180 days after the Accident occurs.
- The Fracture must require, and be corrected by, open (surgical) or closed (non-surgical) reduction by a Physician. Closed reduction includes immobilization.
- We will pay no more than one Fracture Benefit per bone, per Accident.
- If more than one bone is Fractured in a single Accident, the amount We will pay for all Fractures combined will be no more than 2 times the highest Fracture Benefit that would otherwise be payable for any one of the bones involved.
- If an Injury is a Chip Fracture, We will pay the Chip Fracture Benefit instead of the Fracture Benefit. The Chip Fracture Benefit will be 25% of the Fracture Benefit shown in the Schedule for the bone involved.
- If the same Fracture is treated with both open reduction and closed reduction, We will pay no more than the Fracture Benefit payable for the open reduction.

Fracture means a break in a bone of a body part that is listed on the Schedule under Fracture Benefit, which can be detected by an x-ray or a similar diagnostic exam.

Chip Fracture means a Fracture in which a small fragment of the bone is broken off.

DISLOCATION BENEFIT

If a Covered Person sustains an Injury that is a Dislocation, We will pay the Dislocation Benefit, shown in the Schedule, that is applicable to the type of Dislocation the Covered Person sustained, subject to all of the following:

- The Injury must be diagnosed and treated as a Dislocation by a Physician within 180 days after the Accident occurs.
- The Dislocation must require, and be corrected by, open (surgical) or closed (non-surgical) reduction by a Physician.
- If more than one joint is Dislocated in a single Accident, the amount We will pay for all Dislocations combined will be no more than 2 times the highest Dislocation Benefit that would otherwise be payable for any one of the joints involved.
- The Partial Dislocation Benefit will be 25% of the Dislocation Benefit shown in the Schedule for a Full Dislocation of the joint involved.
- If a Partial Dislocation Benefit was paid, or becomes payable, and the Covered Person subsequently sustains an Injury that is a Full Dislocation, We will reduce what We pay for the Full Dislocation by the amount that was paid, or is payable, for the Partial Dislocation.
- For each joint, We will pay no more than one Full Dislocation Benefit amount for all Injuries combined that are Dislocations of that same joint, regardless of whether the Injuries are sustained in the same Accident. Once the Covered Person has received an amount equal to one Full Dislocation Benefit for a joint, no further Dislocation Benefits will be paid for that same joint, even if the Covered Person subsequently sustains an Injury that is a Dislocation of that same joint in a new Accident.
- We will only pay benefits for those Dislocations specifically listed in the Schedule.

Dislocation means a separated joint of a body part that is listed on the Schedule under Dislocation Benefit. The term Dislocation does not include vertebral subluxation complex (misaligned vertebrae).

Full Dislocation means a Dislocation in which the joint is completely separated.

Partial Dislocation means a Dislocation in which the joint is not completely separated.

ACCIDENTAL INJURY BENEFITS (Continued)

BURN BENEFIT

If a Covered Person sustains an Injury that is a second or third degree burn, We will pay the Burn Benefit, shown in the Schedule, that is applicable to the size and severity of the burn, subject to all of the following:

- The burn must be treated by a Physician within 96 hours after the Accident occurs.
- If a burn meets more than one of the burn classifications shown in the Schedule, the amount We pay will be based on the classification of the burn that pays the highest benefit.
- We will pay the Burn Benefit no more than one time per Covered Person, per Accident.
- No benefit is payable for a first degree burn.

CONCUSSION BENEFIT

If a Covered Person sustains an Injury that is a concussion, We will pay the Concussion Benefit shown in the Schedule, subject to all of the following:

- The Injury must be diagnosed as a concussion by a Physician within 96 hours after the Accident occurs.
- We will pay the Concussion Benefit no more than 1 time per Covered Person, per calendar year.

COMA BENEFIT

If a Covered Person sustains an Injury that is a Coma or results in the Covered Person being placed in a medically induced Coma, We will pay the Coma Benefit shown in the Schedule, subject to all of the following:

- The Coma must begin within 180 days after the Accident occurs.
- We will pay the Coma Benefit no more than 1 time per Covered Person, per Accident.

LACERATION BENEFIT

If a Covered Person sustains an Injury that is a Laceration and receives treatment from a Physician to repair it, We will pay the Laceration Benefit, shown in the Schedule, that is applicable to the length of the Laceration and the treatment received as follows:

- if the Laceration is repaired with stitches, We will pay the Laceration Benefit repaired with stitches; or
- if the Laceration is not repaired with stitches, We will pay the Laceration Benefit repaired without stitches.

Payment of the Laceration Benefit is subject to all of the following:

- The Laceration must be treated by a Physician within 96 hours after the Accident occurs.
- A Laceration repaired with sutures or staples will be deemed to be a Laceration repaired with stitches for purposes of this Laceration Benefit.
- If the Covered Person has more than one Laceration, the amount We pay will be based on the total length of all Lacerations received in any one Accident that are repaired with stitches. If some, but not all, of the Lacerations require repair with stitches, We will not pay any benefit for the Laceration or Lacerations that are repaired without stitches.
- We will pay the Laceration Benefit no more than:
  - one time per Covered Person, per Accident; and
  - no more than 3 times per Covered Person, per calendar year.

Laceration means a cut.

ACCIDENTAL INJURY BENEFITS (Continued)

BROKEN TOOTH BENEFIT

If a Covered Person sustains an Injury that is a broken tooth and the tooth is repaired by a dental crown or filling, or is extracted, We will pay the Broken Tooth Benefit, shown in the Schedule, that is applicable to the dental crown, filling and/or extraction, subject to all of the following:

- No benefit will be payable for an Injury to a tooth that is not a sound, natural tooth.
- No benefit will be payable for an Injury caused by biting or chewing.
- The dental services must begin within 180 days after the Accident occurs.
- Regardless of the number of teeth involved, We will pay the Broken Tooth Benefit for no more than 1 dental crown, no more than 1 dental filling, and no more than 1 dental extraction per Covered Person, per Accident.

EYE INJURY BENEFIT

If a Covered Person sustains an Injury to an eye, We will pay the Eye Injury Benefit shown in the Schedule, subject to all of the following:

- The Injury to the eye must require Surgery or the removal of a foreign object by a Physician within 180 days after the Accident occurs.
- We will pay the Eye Injury Benefit no more than 1 time per Covered Person, per Accident.

ACCIDENT - MEDICAL TREATMENT & SERVICES BENEFITS

Payment of the Accident – Medical Treatment and Services Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

AIR AMBULANCE BENEFIT

We will pay the Air Ambulance Benefit shown in the Schedule if a licensed professional air ambulance service is required to transport a Covered Person by air to or from a Hospital or between medical facilities, where treatment for an Injury is received, subject to both of the following:

- The air ambulance transportation must be within 90 days after the Accident occurs.
- We will pay the Air Ambulance Benefit no more than 1 time per Covered Person, per Accident.

GROUND AMBULANCE BENEFIT

We will pay the Ground Ambulance Benefit shown in the Schedule if a licensed professional ambulance service is required to transport a Covered Person by ground to or from a Hospital or between medical facilities, where treatment for an Injury is received, subject to both of the following:

- The ambulance transportation must be within 90 days after the Accident occurs.
- We will pay the Ground Ambulance Benefit no more than 1 time per Covered Person, per Accident.

EMERGENCY CARE BENEFIT OR NON-EMERGENCY INITIAL CARE BENEFIT

If a Covered Person sustains an Injury and receives initial care from a Physician for the Injury in an Emergency Room, a Physician's office or an Urgent Care Facility, within 96 hours after the Accident occurs, We will pay the Emergency Care Benefit, shown in the Schedule that is applicable to the place where care is received.

If a Covered Person sustains an Injury and receives initial care from a Physician for the Injury in an Emergency Room, a Physician's office or an Urgent Care Facility, more than 96 hours but less than 180 days after the Accident occurs, We will pay the Non-Emergency Initial Care Benefit shown in the Schedule.

Payment of the Emergency Care Benefit and the Non-Emergency Initial Care Benefit is subject to both of the following:

- We will never pay both the Emergency Care Benefit and the Non-Emergency Care Benefit for the same Covered Person, for the same Accident.
- If We pay either the Emergency Care Benefit or the Non-Emergency Initial Care Benefit, We will pay the benefit no more than 1 time per Covered Person, per Accident.

ACCIDENT – MEDICAL TREATMENT & SERVICES BENEFITS (Continued)

MEDICAL TESTING BENEFIT

If a Covered Person sustains an Injury and receives any of the following medical tests to evaluate the Injury, We will pay the Medical Testing Benefit shown in the Schedule:

- x-rays;
- magnetic resonance imaging (MRI) or magnetic resonance (MR);
- ultrasound;
- nerve conduction velocity test (NCV);
- computed tomography scan (CT) or computed axial tomography (CAT); or
- electroencephalogram (EEG).

Payment of the Medical Testing Benefit is subject to all of the following:

- The test must be ordered by a Physician and be performed within 180 days after the Accident occurs.
- We will pay the Medical Testing Benefit no more than 2 times per Covered Person, per Accident.

PHYSICIAN FOLLOW-UP VISIT BENEFIT

If a Covered Person sustains an Injury and receives follow-up care, for the Injury, that is recommended by a Physician or is a second opinion, We will pay the Physician Follow-Up Visit Benefit shown in the Schedule, subject to all of the following:

- Treatment must:
  - begin within 180 days after the Accident occurs and be provided within 365 days after the Accident occurs;
  - be specific to the Injury;
  - occur on an outpatient basis in a Physician's office, an Urgent Care Facility or a Hospital; and
  - not be for routine examinations, preventive testing, or any treatment for which a benefit is payable under the Therapy Services Benefit, Emergency Care Benefit or Non-Emergency Initial Care Benefit, or Health Screening Benefit.
- We will pay the Physician Follow-Up Visit Benefit no more than:
  - 2 times per Covered Person, per Accident; and
  - 6 times per Covered Person, per calendar year.

TRANSPORTATION BENEFIT

We will pay the Transportation Benefit shown in the Schedule when a Covered Person travels more than 50 miles one way for follow-up treatment of an Injury for which We pay a benefit under this Certificate, at a Hospital or other treatment facility, subject to all of the following:

- Mileage is measured from the Covered Person’s Primary Residence to the facility where the follow-up treatment is provided.
- The follow-up treatment must be prescribed by a Physician and not available within 50 miles of the Covered Person’s Primary Residence.
- You must submit Proof that the follow-up treatment was provided.
- We will not pay the Transportation Benefit if the Ground Ambulance Benefit or Air Ambulance Benefit is payable for the trip.
- We will pay the Transportation Benefit no more than:
  - 1 time per Covered Person, per Accident; and
  - 2 times per Covered Person, per calendar year.

THERAPY SERVICES BENEFIT

If a Covered Person sustains an Injury and receives Therapy Services, We will pay the Therapy Services Benefit shown in the Schedule that applies to the type of Therapy Service received, subject to all of the following:

- Therapy Services must:
  - begin within 180 days after the Accident occurs and be provided within 365 days after the Accident occurs;
  - be provided on an outpatient basis;
  - be prescribed by a Physician; and
  - be provided by a practitioner licensed to provide the type of Therapy Services provided and operating within the scope of such license.
- We will pay the Therapy Services Benefit for Therapy Services received no more than 10 times per Covered Person, per Accident.
- We will not pay a Therapy Services Benefit for Therapy Services received by the Covered Person on the same day for which the Inpatient Rehabilitation Benefit is payable.

Therapy Services means any of the following:

- cognitive behavioral therapy;
- occupational therapy;
- physical therapy;
- respiratory therapy;
- speech therapy;
- vocational therapy;
- acupuncture; or
- chiropractic therapy.

PAIN MANAGEMENT BENEFIT (FOR EPIDURAL ANESTHESIA)

If a Covered Person sustains an Injury and receives epidural anesthesia to manage the pain from the Injury, We will pay the Pain Management Benefit shown in the Schedule, subject to all of the following:

- The epidural anesthesia must be administered within 180 days after the Accident occurs.
- Epidural anesthesia to manage the pain from the Injury must be prescribed by a Physician.
- We will pay the Pain Management Benefit no more than 1 time per Covered Person, per Accident.

ACCIDENT – MEDICAL TREATMENT & SERVICES BENEFITS (Continued)

PROSTHETIC DEVICE BENEFIT

If a Covered Person sustains an Injury that is a loss of a limb, hand, foot or sight in an eye and receives a Prosthetic Device as a result of the loss, We will pay the Prosthetic Device Benefit, shown in the Schedule, that is applicable to the number of Prosthetic Devices the Covered Person receives, subject to all of the following:

- The Prosthetic Device must be received within 365 days after the Accident occurs.
- No benefit will be payable for replacement of a Prosthetic Device.
- No benefit will be payable for more than one Prosthetic Device for the same body part.
- We will not pay the Prosthetic Device Benefit for a joint replacement such as an artificial hip or knee.
- We will pay the Prosthetic Device Benefit no more than 1 time per Covered Person, per Accident.

Prosthetic Device means an artificial device that replaces a missing body part. The term Prosthetic Device does not include hearing aids, dental aids (including false teeth), eyeglasses, or cosmetic prostheses such as wigs.

MEDICAL APPLIANCE BENEFIT

If a Covered Person sustains an Injury for which a Physician prescribes the use of a Medical Appliance as an aid in personal locomotion or mobility, We will pay the Medical Appliance Benefit, shown in the Schedule, for the type of Medical Appliance that the Physician prescribes, subject to all of the following:

- The use of such Medical Appliance must begin within 180 days after the Accident occurs.
- The amount We will pay for all Medical Appliances combined, per Covered Person, per Accident, will be no more than the Medical Appliances Benefit Limit shown in the Schedule.
- We will not pay the Medical Appliance Benefit for the replacement of a Medical Appliance.

Medical Appliance means any of the following:

- brace for the neck, back or leg;
- cane;
- crutches;
- walker;
- walking boot that extends above the ankle;
- wheelchair or motorized scooter for medical purposes; and
- any other medical device used for mobility.

MODIFICATION BENEFIT

If a Covered Person sustains an Injury for which We paid a Paralysis Benefit under this Certificate, We will pay the Modification Benefit shown in the Schedule for modifications made to the Covered Person's Primary Residence or vehicle, subject to all of the following:

- A Physician must certify that because of the Injury, the modification is necessary to help enable the Covered Person to live in his or her Primary Residence or travel in his or her primary vehicle.
- The modification must be made within 365 days after the Accident occurs.
- We will pay the Modification Benefit no more than 1 time per Covered Person, per Accident.

BLOOD / PLASMA / PLATELETS BENEFIT

If a Covered Person sustains an Injury for which the Covered Person receives a transfusion of blood, plasma or platelets, We will pay the Blood/Plasma/Platelets Benefit shown in the Schedule, subject to all of the following:

- The blood, plasma or platelets must be prescribed by a Physician on an emergency basis or provided while the Covered Person is undergoing Surgery and must be administered within 180 days after the Accident.
- We will pay the Blood/Plasma/Platelets Benefit no more than 1 time per Covered Person, per Accident.

ACCIDENT – MEDICAL TREATMENT & SERVICES BENEFITS (Continued)

SURGERY BENEFITS

If a Covered Person undergoes Covered Surgery to treat an Injury, while Confined or in an Outpatient Surgery Facility, We will pay the applicable benefit shown in the Schedule under Surgery Benefits, for the type of Covered Surgery the Covered Person undergoes, subject to all of the following:

- The Covered Person must be treated by a Physician for the Injury within 180 days after the Accident occurs.
- The Covered Surgery must be performed by a Physician within 365 days after the Accident occurs.
- If the Covered Surgery is performed with repair, We will pay the Surgical Repair Benefit shown in the Schedule for the applicable procedure.
- If the Covered Surgery performed is Exploratory Surgery, We will pay the Exploratory Surgery Benefit shown in the Schedule.
- If as a result of the same Accident, the Covered Person has more than one Covered Surgery performed at the same time, We will only pay a benefit for one Covered Surgery, which will be the Covered Surgery with the highest benefit amount.
- If as a result of the same Accident, the Covered Person has a Covered Surgery and an Other Outpatient Surgery performed at the same time, We will only pay one benefit which will be the benefit that pays the higher amount.
- We will pay Surgery Benefits no more than 1 time per Covered Person, per Accident.

Exploratory Surgery means a Covered Surgery performed without surgical repair. For Surgery to treat torn cartilage in the knee, if cartilage is shaved or trimmed from the knee, the Surgery will be considered Exploratory Surgery and not a Surgery with repair.

OTHER OUTPATIENT SURGERY BENEFIT

If a Covered Person sustains an Injury and undergoes Other Outpatient Surgery to treat the Injury in an Outpatient Surgery Facility, We will pay the Other Outpatient Surgery Benefit shown in the Schedule, subject to all of the following:

- The Covered Person must be treated by a Physician for the Injury within 180 days after the Accident occurs.
- The Surgery must be performed by a Physician in an Outpatient Surgery Facility within 365 days after the Accident occurs.
- If as a result of the same Accident, the Covered Person has a Covered Surgery and an Other Outpatient Surgery performed at the same time, We will only pay one benefit which will be the benefit that pays the higher amount.
- We will pay the Other Outpatient Surgery Benefit no more than 1 time per Covered Person, per Accident.

HOSPITAL BENEFITS

Payment of the Hospital Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

ACCIDENT – HOSPITAL ADMISSION BENEFITS

Admission Benefit

If a Covered Person is admitted to a Hospital for treatment of an Injury, We will pay the Admission Benefit shown in the Schedule, for the day of admission, subject to all of the following:

- The admission must occur within 180 days after the Accident occurs.
- The Admission Benefit is not payable for Emergency Room treatment, outpatient treatment, or a stay of less than 20 hours in an observation area.
- We will only pay the Admission Benefit for a Covered Person for one Hospital admission at a time, even if the admission is caused by more than one Accident and/or Injury.
- We will pay the Admission Benefit no more than 1 time per Covered Person, per Accident.

ICU Supplemental Admission Benefit

If a Covered Person, upon initial admission to a Hospital for treatment of an Injury, is admitted to an ICU, We will pay the ICU Supplemental Admission Benefit shown in the Schedule, in addition to the Admission Benefit, if the admission meets the requirements for payment of the Admission Benefit, subject to both of the following additional requirements:

- The admission must occur within 180 days after the Accident occurs.
- If the Covered Person moves to an ICU after initial admission to a Hospital, We will not pay the ICU Supplemental Admission Benefit.

ACCIDENT - HOSPITAL CONFINEMENT BENEFITS

Confinement Benefit

If a Covered Person is Confined in a Hospital for treatment of an Injury, We will pay the Confinement Benefit shown in the Schedule for each day, after the day of admission to the Hospital, the Covered Person is Confined in the Hospital, subject to all of the following:

- The initial Confinement must begin within 180 days after the Accident occurs.
- The Confinement Benefit is payable for up to 15 days per Covered Person, per Accident, and may be used over a two-year period following the date of the Accident.
- We will only pay the Confinement Benefit for a Covered Person for one Hospital Confinement at a time, even if the Confinement is caused by more than one Accident and/or Injury.
- We will only pay one Confinement Benefit per day.

ICU Supplemental Confinement Benefit

If a Covered Person is Confined in a Hospital for treatment of an Injury, We will pay the ICU Supplemental Confinement Benefit shown in the Schedule in addition to the Confinement Benefit, for each day the Covered Person is Confined in an Intensive Care Unit and meets the requirements for payment of the Confinement Benefit, subject to both of the following additional requirements:

- Confinement in the Intensive Care Unit must begin within 180 days after the Accident occurs.
- The ICU Supplemental Confinement Benefit is payable for up to 15 days per Covered Person, per Accident.

INPATIENT REHABILITATION BENEFIT

If a Covered Person is transferred to a Rehabilitation Facility immediately after a period of Confinement for treatment of an Injury for which We paid an Admission Benefit or Confinement Benefit, We will pay the Inpatient Rehabilitation Benefit shown in the Schedule, subject to all of the following:

- We will pay the Inpatient Rehabilitation Benefit for each day of the Covered Person's continuous stay as a resident inpatient in a Rehabilitation Facility, up to a maximum stay of 15 days per Covered Person, per Accident but not to exceed 30 days per calendar year.
- The Covered Person's inpatient stay in the Rehabilitation Facility must start within 365 days after the Accident.
- After the Covered Person is discharged from the Rehabilitation Facility, We will not pay the Inpatient Rehabilitation Benefit for a subsequent admission to a Rehabilitation Facility for treatment of the same Injury for which We already paid the Inpatient Rehabilitation Benefit.
- We will not pay the Inpatient Rehabilitation Benefit for any day for which We paid a Confinement Benefit.

OTHER BENEFITS

Payment of the Other Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

HEALTH SCREENING BENEFIT

If a Covered Person takes one of the screening/prevention measures listed below while insured under this Certificate, upon submission of Proof, We will pay the Health Screening Benefit shown in the Schedule for the day that the measure is taken, subject to all of the following:

- We will only pay the Health Screening Benefit 1 time per Covered Person, per calendar year.
- We will not pay a Health Screening Benefit for a screening/prevention measure if benefits are paid or payable for that same screening/prevention measure under another section of this Certificate.

The screening/prevention measures for which a Health Screening Benefit may be paid are:

- routine health check-up exam
- blood chemistry panel
- chest x-rays
- complete blood count (CBC)
- electrocardiogram (EKG)
- electroencephalogram (EEG)

OTHER BENEFITS (Continued)

LODGING BENEFIT

If a Covered Person is Confined in a Hospital for treatment of an Injury, and a companion who accompanies the Covered Person while the Covered Person is so Confined stays in a Lodging for which a charge is made, We will pay the Lodging Benefit shown in the Schedule subject to all of the following:

- We will pay the Lodging Benefit for each day the companion stays in a Lodging while the Covered Person is Confined in a Hospital for treatment of an Injury.
- We will pay the Lodging Benefit for up to 15 days per Covered Person per calendar year.
- The Lodging Benefit is only payable for a day for which We are paying a Hospital Admission or Confinement Benefit for a Covered Person.
- You must submit Proof that the companion incurred an expense for staying at a Lodging for each day of the stay.

Lodging means an establishment licensed under the laws where it is located, such as a motel, hotel, or other facility that provides sleeping accommodations to the general public in exchange for a fee and is located at least 50 miles from the Covered Person's Primary Residence.

EXCLUSIONS

We will not pay benefits for any loss for a Covered Person caused by the Covered Person's Sickness, or the diagnosis or treatment of such Sickness, except for the Covered Person's use of:

- any drug, medication or sedative that is taken or used as prescribed by a Physician; or
- an "over the counter" drug, medication or sedative taken as directed.

We will not pay benefits for any loss for a Covered Person caused or contributed to by:

- the Covered Person's voluntary use, by any means, of:
  - any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a Physician; or
    - an "over the counter" drug, medication or sedative taken as directed;
  - alcohol in combination with any drug, medication, or sedative; or
  - poison, gas, or fumes;
- the Covered Person's suicide or attempted suicide (while sane or insane);
- the Covered Person's intentionally self-inflicted injury;
- war, whether declared or undeclared; or act of war;
- the Covered Person's active participation in an insurrection, rebellion, riot, or terrorist act;
- the Covered Person's engagement in any activity that constitutes a felony under the laws of the jurisdiction in which the activity occurred;
- the Covered Person's infection, other than infection occurring in an external wound resulting from an Injury;
- food poisoning;
- the Covered Person's operation, while intoxicated, of a motor vehicle involved in the incident. For purposes of this exclusion:
  - intoxicated means that the Insured's blood alcohol level met or exceeded .08%; and
  - motor vehicle means any vehicle that is powered by a motor, including, but not limited to: an automobile; a boat; a motorcycle; a truck; an all-terrain vehicle; or a snow mobile;
- dental or plastic Surgery for cosmetic purposes, except when such Surgery is performed to:
  - treat an Injury;
  - correct a disorder of normal bodily function or structure that was caused by an Injury for which coverage is not otherwise excluded under this Certificate; or
  - reconstruct a part of the body which was disfigured or removed as a result of an Injury for which coverage is not otherwise excluded under this Certificate;
- the Covered Person's mental illness, or the diagnosis or treatment of such mental illness, except for the Covered Person's use of:
  - any drug, medication or sedative that is taken or used as prescribed by a Physician; or
  - an "over the counter" drug, medication or sedative taken as directed;
- activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority;
- the Covered Person's travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight;
- the Covered Person parachuting or otherwise exiting from a motorized or non-motorized aircraft while such aircraft is in flight, except for self-preservation;
- the Covered Person riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- the Covered Person participating in any semi-professional or professional competitive athletic activity for which any type of compensation or remuneration is received; or
- the Covered Person bungee jumping, base jumping, hang gliding, para-kiting, sail-gliding, scuba diving deeper than 130 feet; spelunking; or mountaineering including rock climbing using ropes and any other climbing equipment. For the purposes of this exclusion the term mountaineering does not include backpacking, mountain biking, hiking or trail running.

EXCLUSIONS (Continued)

In addition, We will not pay benefits for:

- a Covered Person while incarcerated in any type of penal or detention facility; or
- any of the following outside of the United States, Canada or Mexico:
  - any medical or healthcare treatment, services or transportation described in the Accident – Medical Treatment & Services Benefits section of this Certificate;
  - any inpatient admission or stay in any medical or health care facility.

WHEN INSURANCE ENDS

Please Note: If insurance ends under this section, in certain cases it may be continued as stated in the Continuation of Insurance section of this Certificate. Please see that section for details.

Termination of a Covered Person's insurance in accordance with this section, will be without prejudice to an existing claim.

DATE YOUR INSURANCE ENDS

Your insurance under this Certificate will end on the earliest of:
- the date the Group Policy ends;
- the date You die;
- the date insurance ends for Your class;
- the end of the period for which the last full premium has been paid for Your insurance;
- the end of the calendar month in which You notify Us that You wish to cancel Your insurance;
- the end of the calendar month in which You cease to be in an eligible class, subject to the Change in Class provision of the Eligibility Provisions: Insurance for You section; or
- the end of the calendar month in which Your employment ends.

For residents of Massachusetts:

If You are a resident of Massachusetts and Your insurance under this Certificate is ending under the above provision because Your employment has ended, instead of insurance ending on the date Your employment ends, the following timelines apply:

- If Your employment ends for any reason other than a Plant Closing or a Partial Plant Closing, Your insurance will end 31 days after the date Your employment ends. However, if during such 31 day period You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate, insurance under this Certificate will end on the date You become entitled to such other benefits.

- If Your employment ends due to a Plant Closing or a Partial Plant Closing Your insurance will end 90 days after the date Your employment ends. However, if during such 90 day period, You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate insurance under this Certificate will end on the date You become entitled to such other benefits.

DATE DEPENDENT INSURANCE ENDS

A Dependent's insurance under this Certificate will end on the earliest of:
- the date Your insurance under this Certificate ends;
- the date Dependent Insurance ends under the Group Policy for all employees or for Your class;
- the end of the calendar month in which the person ceases to be a Dependent;
- the end of the calendar month in which You cease to be in a class that is eligible for Dependent Insurance;
- the end of the calendar month in which the Dependent is no longer eligible as described in the Eligible Classes for Dependent Insurance provision; or
- the end of the period for which the last full premium has been paid for insurance for the Dependent.

CHANGE IN CLASS

If there is more than one class eligible for insurance under the Group Policy, and each class has its own certificate, instead of receiving a new certificate when You move between classes, You will remain insured under this Certificate if:
- You move to a class that is eligible for Accident Insurance under the Group Policy; and
- the benefits available to Your new class are identical to the benefits available under this Certificate.

In all other cases when You move between classes, Your insurance under this Certificate will end on the date You are no longer a member of the class eligible for insurance under this Certificate.

CONTINUATION OF INSURANCE

AT YOUR OPTION: CONTINUATION WITH PREMIUM PAYMENT

If Your insurance ends under the Date Your Insurance Ends provision of this Certificate, in certain situations, it may be continued for You and Your Dependents, as described in this provision. This is referred to in this provision as "Continued Insurance". Evidence of insurability will not be required to obtain Continued Insurance. For purposes of this provision, insurance in effect under the Group Policy for which the Group Policyholder remits premium is referred to in this provision as "Group Billed Insurance".

Except as described below, Continued Insurance is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

Requirements for Continued Insurance

Continued Insurance will be available to You if:

- Your Group Billed Insurance ends for any reason other than:
  - non-payment of premium or Contribution; or
  - the end of the Group Policy, provided that Continued Insurance will be available to You if You do not become eligible, within 30 days after the end of the Group Policy, for accident insurance under another policy of group insurance available through the Group Policyholder;
- We receive Your completed Written request for Continued Insurance on a form approved by Us within 31 calendar days after Your Group Billed Insurance ends; and
- You pay premiums required for Continued Insurance by the due date specified in the premium notice sent to You.

Changes in Continued Insurance

You may elect to decrease Your insurance after the date that Continued Insurance goes into effect for You if a lower benefit option is available. In addition, You may end insurance for any or all of Your Dependents. Please contact Us for information. You may not increase insurance once Continued Insurance goes into effect.

Contributions for Continued Insurance

The Contribution that You must pay for Continued Insurance is the amount of Your Contribution for Your Group Billed Insurance before it ended, plus any amount of premium that the Group Policyholder paid. The Contribution that You must pay for Continued Insurance will be determined on the same basis as premium rates charged for Group Billed Insurance. We have the right to change premium rates in accordance with the terms set forth in the Group Policy. All payments for Continued Insurance must be made directly to Us by the due date specified in the premium notice We send to You.

End of Continued Insurance

Continued Insurance will end on the earliest of the following dates:

- the date You die;
- if You do not pay a Contribution that is required for Continued Insurance, the end of the period for which the last full premium has been paid for Your insurance;
- with respect to Continued Insurance for a Dependent:
  - the date Continued Insurance for You ends for any reason;
  - the end of the calendar month in which the Dependent no longer meets the definition of a Dependent; or
  - the end of the calendar month in which the Dependent is no longer eligible as described in the Eligibility Provisions: Dependent Insurance section of this Certificate.

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if that child is incapable of self-sustaining employment and is chiefly dependent on You for support and maintenance because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Dependent Child attains the age limit and at reasonable intervals after such date, but no more often than annually after the two year period following such Dependent Child's attainment of the limiting age.

Except as stated in the Date Dependent Insurance Ends provision of the When Insurance Ends section of this Certificate, insurance will continue while such Dependent Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap;
- remains chiefly dependent on You for support and maintenance; and
- continues to qualify as a Dependent Child, except for the age limit.

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify under the Family and Medical Leave Act of 1993 (FMLA) or similar state laws for continuation of insurance. Please contact the Group Policyholder for information regarding the FMLA or any similar state law.

CLAIMS

NOTICE OF CLAIM

You must give Us notice of a claim under this Certificate by Writing to Us or calling Us at the toll free number shown on the face page of this Certificate within 30 days of the date of the loss.

CLAIM FORM

When We receive notice of a claim under this Certificate, We will provide You or the claimant (for a death claim) with a claim form. If We do not provide the claim form before the 16th day from the date We received notice of claim, Our claim form requirements will be satisfied if We are provided with the required Proof in support of the claim.

PROOF OF LOSS

Proof must be provided to Us not later than 90 days after the date of the loss. If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible, but in no event, other than in the absence of the legal capacity of the claimant, later than 15 months from the date of the loss. When We receive the claim form and Proof, We will review the claim and, provide notification in Writing of Our approval or denial of the claim no later than the 15th business day after the date We receive documentation in support of the claim.

PAYMENT OF BENEFITS

If We approve a claim, We will pay benefits no later than 60 days after the date We receive the claim form and Proof, subject to the terms and provisions of this Certificate and the Group Policy. If We deny the claim, Our notice will state the reason(s) for the denial. If We cannot approve or deny the claim within 15 business days after We receive documentation in support of the claim, We will provide notification within 15 business days, stating that We need additional time to review the claim and the reason(s) why. We will notify You or the claimant of Our decision to approve or deny the claim within 45 days after the date that We provide notification that We need additional time to review the claim.

Unless You have assigned this insurance, all benefits to be paid under this Certificate will be paid to You, except as follows:

- If You are not alive to receive benefits that are payable to You, We will pay any benefits in accordance with the provision below titled Your Beneficiary.
- If You are living when benefits are to be paid to You, but You are not legally competent to claim or receive the benefits, We may pay up to $10,000 to anyone related to You by blood or marriage who We believe is entitled to payment of the benefits. If We make such a payment in good faith, We will not be liable to anyone for the amount We pay. Any remaining benefits will be paid to Your legal representative.

If benefits have been assigned, We will pay benefits in accordance with the Assignment provision of the General Provisions section.

YOUR BENEFICIARY

A beneficiary may be named by You to receive any benefit that becomes payable to You under this Certificate that You are not alive to receive.

You may request to change Your beneficiary at any time. A beneficiary change request must be made to Us in Writing. Once the request is recorded, the change will take effect as of the date You sign the request, whether or not You are living when We receive the request. The change will be subject to any legal restrictions. It will also be subject to any payment We made or action We took before We recorded the change. If You designated two or more beneficiaries and their shares are not specified, they will share the benefit payable equally.

If there is no beneficiary designated or no surviving beneficiary at Your death, We will determine the beneficiary according to the following order:

1. Your Spouse, if alive;
2. Your child(ren), if there is no surviving Spouse;
3. Your parent(s), if there is no surviving child;
4. Your sibling(s), if there is no surviving parent; or
5. Your estate, if there is no surviving sibling.

Instead of making payment in the order above, We may pay Your estate. Any payment made in good faith will discharge Our liability to the extent of such payment. If a beneficiary or a Payee is a minor or incompetent to receive payment, We will pay that person's guardian.

AUTHORIZATIONS

We may require that You provide authorization for Us to obtain medical information and any other information pertinent to Your claim.

EXAMINATIONS

During the pendency of a claim, at Our expense and as often as is reasonably necessary, We may require a Covered Person to have an independent examination by a Physician of Our choice.

During the pendency of a claim, at Our expense and as often as is reasonably necessary, We may have Our representatives conduct telephone or in-person interviews with You regarding Your claim.

AUTOPSY

At Our expense, We have the right to make a reasonable request for an autopsy and/or exhumation where permitted by law. Any such request will set forth the reasons We are requesting the autopsy or exhumation.

TIME LIMIT ON LEGAL ACTIONS

A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends three years after the date such Proof is required to be filed.

GENERAL PROVISIONS

ENTIRE CONTRACT

Your insurance is provided under a contract of group insurance with the Group Policyholder. The entire contract with the Group Policyholder is made up of the following:

- the Group Policy and its Exhibits, which include the Certificate(s);
- the Group Policyholder's application; and
- any amendments and/or endorsements to the Group Policy.

INCONTESTABILITY: STATEMENTS MADE BY YOU

Any statement made by You will be considered a representation and not a warranty. We will not use such a statement to void insurance, reduce benefits or defend a claim unless the following requirements are met:

- the statement is in a form that is in Writing;
- You have Signed the form; and
- a copy of the form has been given to You or Your beneficiary.

We will not use Your statements which relate to insurability to contest this insurance after it has been in force for 2 years, unless the statement is fraudulent. In addition, We will not use such statements to contest a benefit increase after the benefit increase has been in force for 2 years, unless such statement is fraudulent.

MISSTATEMENTS

If Your or Your Dependent's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or Contributions.

ASSIGNMENT

The benefits under the Group Policy are not assignable prior to a claim for benefits, except to a Physician or other health care provider who provides health care services to You, or except as required by law or permitted by Us.

CONFORMITY WITH LAW

If the terms and provision of this Certificate do not conform to any applicable law, this Certificate shall be interpreted to so conform.

STANDARD OF TIME

All insurance becomes effective and terminates at 12:01 A.M. Eastern Standard Time, or at 12:01 A.M. Eastern Daylight Time if Daylight Savings Time is then being observed.

MetLife

Voluntary Critical Illness – MetLife Plan

Critical Illness insurance is coverage that can help safeguard your finances by providing you with a lump-sum payment when you or your family may need it most. This lump-sum payment allows you to pay for whatever you need, such as expenses that may not be covered by your main medical plan (e.g., copays, deductibles, childcare, mortgage, groceries and experimental treatments).

Covered Conditions	Initial Benefit	Recurrence Benefit
Invasive Cancer	100% of Benefit Amount	100% of Initial Benefit
Heart Attack	100% of Benefit Amount	100% of Initial Benefit
Coma	100% of Benefit Amount	100% of Initial Benefit
Childhood Diseases – Cerebral Palsy, Cystic Fibrosis, Cleft Lip or Cleft Palate, Down Syndrome, T1 Diabetes	100% of Benefit Amount	None
Kidney Failure	100% of Benefit Amount	None
Stroke	100% of Benefit Amount	100% of Initial Benefit
Major Organ Transplant	100% of Benefit Amount	None
Infectious Diseases - 5 days consecutive hospitalization required	25% of Benefit Amount	None
Health Screening Benefit	**$100 1 time per calendar year for all enrolled; pays IF you have your annual wellness visit.**	None

$15,000 Employee Benefit Amount – Bi-weekly Rates				
ATTAINED AGE	EMPLOYEE ONLY	EMPLOYEE AND SPOUSE	EMPLOYEE AND CHILD(REN)	EMPLOYEE AND FAMILY
<25	$2.56	$4.43	$4.08	$5.95
25-29	$2.84	$4.85	$4.36	$6.37
30-34	$3.25	$5.54	$4.78	$7.06
35-39	$3.95	$6.58	$5.47	$8.10
40-44	$5.12	$8.31	$6.65	$9.83
45-49	$6.78	$10.87	$8.31	$12.39
50-54	$8.93	$13.85	$10.45	$15.37
55-59	$12.32	$18.69	$13.85	$20.22
60-64	$16.27	$24.30	$17.79	$25.82
65-69	$22.50	$33.16	$24.02	$34.68
70+	$31.43	$46.25	$32.95	$47.77

$30,000 Employee Benefit Amount – Bi-weekly Rates				
ATTAINED AGE	EMPLOYEE ONLY	EMPLOYEE AND SPOUSE	EMPLOYEE AND CHILD(REN)	EMPLOYEE AND FAMILY
<25	$5.12	$8.86	$8.17	$11.91
25-29	$5.68	$9.69	$8.72	$12.74
30-34	$6.51	$11.08	$9.55	$14.12
35-39	$7.89	$13.15	$10.94	$16.20
40-44	$10.25	$16.62	$13.29	$19.66
45-49	$13.57	$21.74	$16.62	$24.78
50-54	$17.86	$27.69	$20.91	$30.74
55-59	$24.65	$37.38	$27.69	$40.43
60-64	$32.54	$48.60	$35.58	$51.65
65-69	$45.00	$66.32	$48.05	$69.37
70+	$62.86	$92.49	$65.91	$95.54

View the Critical Illness Insurance Certificate by clicking **here.**



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10116-0188

Metropolitan Life Insurance Company ("MetLife"), a stock company, will pay the benefits specified in the Exhibits of this policy subject to the terms and provisions of this policy. The Schedule of Exhibits lists each Exhibit to this policy, to whom it applies and its effective date.

Policyholder: ClubCorp USA, Inc.

Group Policy No.: 0119217

EFFECTIVE DATE

This policy will take effect on January 1, 2023.

POLICY ANNIVERSARIES

Policy anniversaries will be January 1, 2024 and each subsequent January 1.

PREMIUM PAYMENTS

This policy is issued in return for the payment of required Premiums. Premiums are payable at the home office of MetLife or to its authorized agent. The first Premium is due on, and must be paid by this policy's effective date. Any later Premiums are due monthly on the 1st day of the Policy Month. These dates are the Premium Due Dates.

POLICY SITUS

This policy is issued for delivery in and governed by the laws of Texas.

Signed as of this policy's effective date at MetLife's home office in New York, New York.

Timothy J. Ring
Secretary

Michel Khalaf
President & CEO

Signed by _____
(A licensed MetLife agent or resident agent if required by law.)

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

Notice: This is a critical illness insurance policy. Subject to the provisions of this policy, including limitations, exclusions and submission of proof of a covered condition, this policy provides a limited benefit in the event a Covered Person is diagnosed with certain specified diseases, or has certain surgical procedures performed. Benefits provided are a supplement, and not a substitute for, medical coverage.

GROUP CRITICAL ILLNESS INSURANCE POLICY
NON-DIVIDEND PAYING

Have a complaint or need help?

If You have a problem with a claim or Your premium, call Your insurance company or HMO first. If You can't work out the issue, the Texas Department of Insurance may be able to help.

Even if You file a complaint with the Texas Department of Insurance, You should also file a complaint or appeal through Your insurance company or HMO. If You don't, You may lose Your right to appeal.

Metropolitan Life Insurance Company

To get information or file a complaint with Your insurance company or HMO:

Call: Corporate Consumer Relations Department at 1-800-438-6388

Toll-free: 1-800-438-6388

Email: Johnstown_Complaint_Referrals@metlife.com

Mail: Metropolitan Life Insurance Company
700 Quaker Lane, 2nd Floor
Warwick, Rhode Island 02886

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Metropolitan Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388

Teléfono gratuito: 1-800-438-6388

Correo electrónico: Johnstown_Complaint_Referrals@metlife.com

Dirección postal: Metropolitan Life Insurance Company
700 Quaker Lane, 2nd Floor
Warwick, Rhode Island 02886

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

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DEFINITIONS

As used in this policy, the terms listed below will have the meanings defined below. When defined terms are used in this policy, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Covered Person means an Employee and/or a Dependent as set forth in the Exhibits attached to this policy which applies to the Employee.

Dependent means an individual who is eligible for insurance as provided in the Exhibits attached to this policy.

Employee means an individual who is eligible for insurance as an Employee as set forth in the Exhibits attached to this policy which applies to that individual.

Employer means the Policyholder shown on page 1 and any subsidiaries, affiliates, divisions, branches or other similar entities of such Policyholder as specified in Exhibit 3.

Policy Anniversary is defined on page 1.

Policy Month. The first Policy Month will begin on the effective date shown on page 1. Subsequent Policy Months will begin on the same day of each subsequent calendar month.

Premium means the amount that must be paid to MetLife for all the insurance provided under this policy.

Premium Due Date is defined on page 1.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

Written or **Writing** means a record which is on or transmitted by paper or electronic media, and that is consistent with applicable law.

SCHEDULE OF INSURANCE

The Schedules of Insurance which apply under this policy are set forth in the Exhibits attached to this policy.

ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

The Eligibility and Effective Dates of Insurance provisions that apply under this policy are set forth in the Exhibits that are attached to this policy.

CONTRIBUTIONS

The maximum amount that an Employee may be required to contribute to the cost of insurance will not exceed the Premium charged for the amounts of such insurance.

PREMIUM RATE(S)

Initial Rate(s)

The initial Premium rate(s) are shown in Exhibit 1.

Frequency of Premium Payment

Premiums for this policy will be paid as shown on page 1. MetLife and the Policyholder may agree that payment be made in advance every 3, 6 or 12 months.

Computation of Premium

The Premium due on any Premium Due Date is determined by the total amount of insurance provided by this policy on such Premium Due Date, multiplied by the appropriate Premium rate(s) which are then in effect subject to any Premium adjustments, if applicable.

MetLife may use any reasonable method to compute Premiums due under this policy.

Premiums for Changes in Insurance

For insurance that takes effect after the first day of a Policy Month, Premium will be charged from the first day of the next Policy Month. However, if a policy amendment or evidence of good health is required for such insurance, Premium will be charged as of the date such insurance takes effect. If insurance ends, Premium will be charged to the date insurance ends.

PREMIUM RATES (Continued)

Right to Change Premium Rates

MetLife may change Premium rates for changes which materially affect the risk assumed for the insurance provided by this policy, as follows:

1. when this policy is amended or endorsed;

2. when a class of eligible persons is added to or deleted from this policy for any reason including corporate restructuring, acquisition, spin-off or similar situations;

3. when a Policyholder's subsidiary, affiliate, division, branch or other similar entity is added to or deleted from this policy for any reason including corporate restructuring, acquisition, spin-off or similar situations;

4. when there is a significant change in the geographic distribution of insured Employees;

5. when applicable law requires a change in:

    a. the insurance provided by this policy; and/or
    b. the class of persons eligible for insurance under this policy; or

6. when a Premium Due Date coincides with or next follows:

    a. a change greater than 10% in the number of Covered Persons since the later of the policy Effective Date and the last date Premium rates were changed; or

    b. a change greater than 10% in the amount of insurance provided by this policy since the later of the policy Effective Date and the last date Premium rates were changed.

In addition, MetLife may change Premium rates:

1. except as may be stated in Exhibit 1, on any date on or after the first Policy Anniversary; this will be done no more frequently than every 12 months and only if MetLife notifies the Policyholder, in Writing, at least 60 days before such change; and

2. on any other date agreed to by MetLife and the Policyholder.

The new Premium rates will apply only to Premiums due on or after the date the rate change takes effect.

GRACE PERIOD

Each Premium due after the effective date of this policy may be paid up to 60 days after its Premium Due Date. This period is the grace period. The insurance provided by this policy will stay in effect during this period. MetLife will notify the Policyholder in Writing that, if the Premium is not paid by the end of the grace period, this policy will end at the end of the last day of the grace period. If MetLife fails to give Written notice to the Policyholder, this policy will continue in effect until the date such notice is given.

Policyholder's intent to end this policy during the grace period. The Policyholder may notify MetLife in Writing prior to the end of the grace period of its intent to end this policy before the end of the grace period. In this case, this policy will end on the later of:

1. the date stated in the notice; or
2. the date MetLife receives the notice.

If the Policyholder replaces this policy with another group insurance policy but does not give MetLife notice of intent to end this policy, the grace period provisions will apply.

Grace period extensions. MetLife may extend the grace period by giving Written notice to the Policyholder. Such notice will state the date this policy will end if the Premium remains unpaid.

Premiums must be paid for a grace period, any extension of such period and any period insurance under this policy was in effect for which Premium was not paid.

END OF INSURANCE PROVIDED BY THIS POLICY

The Policyholder can end this policy by giving 31 days advance Written notice to MetLife. The policy will end on the later of:

1. the date stated in the notice; or
2. the date MetLife receives the notice.

MetLife can end this policy as follows:

1. on the date Premium is not paid when due, subject to the Grace Period provisions;

2. on any Premium Due Date, by giving the Policyholder 31 days advance Written notice, if less than:

    a. 5**%** of persons eligible under this policy are insured for Contributory Insurance;
    b. 100% of persons eligible under this policy are insured for Noncontributory Insurance; or
    c. 10 Employees are insured by this policy;

3. on any Premium Due Date, by giving the Policyholder 60 days advance Written notice, if the Policyholder fails to provide information on a timely basis or perform any obligations required by this policy or any applicable law; or

4. on any Policy Anniversary, except during a Rate Guarantee Period as may be provided in Exhibit 1, by giving the Policyholder 31 days advance Written notice.

This policy will end on the date on which the last certificate in effect under this policy ends.

If this policy ends, all Premiums due must be paid. If MetLife accepts Premium after the date this policy ends, such acceptance will not act to reinstate the policy. MetLife will refund any unearned Premium.

GENERAL PROVISIONS

Entire Contract. The entire contract is made up of the following:

1. this policy, including its Exhibits, which include the certificates attached as Exhibits to this policy;
2. the enrollment forms, if any, of those Employees who are Covered Persons;
3. the Policyholder's application; and
4. the amendments and endorsements to this policy, if any.

Policy Changes or Waivers. The terms and provisions of this policy may be changed, at any time, without the consent of the Covered Persons or anyone else with a beneficial interest in it. MetLife will issue amendments or endorsements to effect such changes. MetLife will only make changes that are consistent with applicable law. An amendment or endorsement will not affect the insurance provided under certificates issued before the effective date of the change, unless retroactivity is consistent with applicable law.

An officer of MetLife must approve in Writing any change or waiver of the terms and provisions of this policy. A sales representative, or other MetLife employee, who is not an officer of MetLife does not have MetLife's authority to approve such changes or waivers. A change or waiver will be evidenced by an amendment Signed by an officer of MetLife and the Policyholder or an endorsement Signed by an officer of MetLife. A copy of the amendment or endorsement will be provided to the Policyholder for attachment to this policy.

Incontestability: Statements Made by the Policyholder. Any statement made by the Policyholder will be considered a representation and not a warranty. MetLife will not use such statement to avoid insurance, reduce benefits or defend a claim unless it is contained in a Written application. MetLife will not use such statement to contest insurance after it has been in force for 2 years from its effective date, or date of last reinstatement, unless the statement is fraudulent.

Incontestability: Statements Made by Covered Persons. Any statement made by a Covered Person will be considered a representation and not a warranty. MetLife will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. the Covered Person has Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to the Covered Person or his beneficiary.

MetLife will not use a Covered Person's statements which relate to insurability to contest insurance after it has been in force for 2 years, unless the statement is fraudulent. In addition, MetLife will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years, unless such statement is fraudulent.

Certificates. MetLife will issue certificates to the Policyholder, for delivery to each Employee covered under the policy, a certificate that has been prepared for each such Employee so as to describe the Employee's benefits and rights under this policy.

Assignment. The rights and benefits under this policy are not assignable, except to a physician or other health care provider who provides health care services to a Covered Person, or except as required by law or as permitted by MetLife.

Information Needed and Policy Administration

All information necessary to compute Premiums and carry out the terms of this policy will be provided by the Policyholder to MetLife. Such information:

- Will be provided in a timely manner and in a format as agreed to by MetLife and the Policyholder;
- Will be provided, maintained and administered as agreed to in Writing by MetLife and the Policyholder; and
- If maintained by the Policyholder, may be examined by MetLife at any reasonable time.

If MetLife or the Policyholder makes a clerical error in keeping or providing the information, the Premium and/or benefits will be adjusted as warranted, according to the correct information. An error will not end insurance validly in effect, nor will it continue insurance validly ended or create insurance coverage where no coverage existed.

Any act undertaken by the Policyholder that relates to the insurance provided under this policy must be consistent with the terms of such insurance and with MetLife's requirements; including but not limited to the eligibility requirements of the Policyholder's plan as set forth in the certificates to this policy.

Misstatement of Age. If a Covered Person's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, adjust the Premium and/or benefits.

Non-Dividend Paying. This policy does not pay dividends.

Conformity with Law. If the terms and provisions of this policy do not conform to any applicable law, this policy shall be interpreted to so conform.

Standard of Time. All coverage becomes effective and terminates at 12:01 A.M. Eastern Standard Time, or at 12:01 A.M. Eastern Daylight Time if Daylight Saving Time is then being observed.

SCHEDULE OF EXHIBITS

Exhibit Number	Exhibit Type	Applies To	Effective Date
1	Schedule of Premium Rates	All Covered Persons	January 1, 2023
2	Certificate Forms	All Employees	January 1, 2023
3	List of Policyholder's Subsidiaries, Affiliates, Divisions, Branches and Other Similar Entities	All Covered Persons	January 1, 2023

EXHIBIT 1

SCHEDULE OF PREMIUM RATES

The initial monthly Premium rates for the insurance provided by this policy are as follows:

Rates are determined separately for each Employee and are based on:

- whether the Employee insures any Dependents; and
- the Employee's age as of the last plan anniversary.

Premium rates below are shown based on $1,000 of coverage.

CLASS 1: All Active Full-Time Employees

Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Spouse + Child(ren)
< 25	$0.37	$0.64	$0.59	$0.86
25- 29	$0.41	$0.70	$0.63	$0.92
30- 34	$0.47	$0.80	$0.69	$1.02
35- 39	$0.57	$0.95	$0.79	$1.17
40- 44	$0.74	$1.20	$0.96	$1.42
45- 49	$0.98	$1.57	$1.20	$1.79
50- 54	$1.29	$2.00	$1.51	$2.22
55- 59	$1.78	$2.70	$2.00	$2.92
60- 64	$2.35	$3.51	$2.57	$3.73
65- 69	$3.25	$4.79	$3.47	$5.01
70+	$4.54	$6.68	$4.76	$6.90

EXHIBIT 1 - SCHEDULE OF PREMIUM RATES (Continued)

Rate Guarantee Period

Subject to the Right to Change Premium Rates provision on page 5, these Premium rates will be in effect from January 1, 2023 to December 31, 2027.

Employees who become insured for Group Critical Illness Insurance under the Group Policy will have access to certain non-insured Healthcare Navigation Services. These services will be available for Employees, their enrolled Dependents and any of the following family members of the Employee, without regard to Dependent status: spouses or domestic/civil union partners; children; parents; and parents-in-law at no additional premium. MetLife has arranged for these services to be provided by a third-party service provider. The services include access to education and support from personal consultants with healthcare expertise, including the following: decision support related to health care services and benefits; assistance with understanding health benefits; concierge services to coordinate care, assess costs of care, find doctors and facilitate appointments; medical claim/bill review and correction. The services also include access to self-service decision support tools via a web portal that can be used to assess costs of care and find doctors. MetLife is not responsible for providing or failing to provide these services nor is it liable for any negligence in the provision of such services by the third-party service provider. While Employees, their enrolled Dependents and family members may receive health care provider suggestions and cost estimates, care coordination and education regarding diagnosis and treatments as part of the Healthcare Navigation Services, their physicians or other health care providers remain responsible for the actual medical care and the associated outcomes and costs. Healthcare Navigation Services may be terminated by MetLife or the Policyholder at any time.

EXHIBIT 2

CERTIFICATE FORMS

The coverage plans available under this policy are as follows:

Class 1
Critical Illness Plan 1

Certificates for each coverage plan available under this policy are issued to the Policyholder for delivery to certificateholders as follows:

- certificates to be delivered to certificateholders who, on their certificate effective date, reside in the following jurisdictions:
  - Alaska
  - Arkansas
  - Colorado
  - Connecticut
  - Florida
  - Idaho
  - Louisiana
  - Minnesota
  - Mississippi
  - Missouri
  - Montana
  - Nebraska
  - New Hampshire
  - New Mexico
  - North Carolina
  - North Dakota
  - Ohio
  - Oklahoma
  - South Carolina
  - South Dakota
  - Utah
  - Vermont
  - Washington
  - West Virginia
  - Wisconsin
  - Wyoming
- a Texas certificate for delivery to certificateholders who, on their certificate effective date, reside in all other jurisdictions.

EXHIBIT 3

LIST OF POLICYHOLDER SUBSIDIARIES, AFFILIATES, DIVISIONS, BRANCHES AND OTHER SIMILAR ENTITIES

The subsidiaries, affiliates, divisions, branches and other similar entities listed below are included for insurance under this policy as of the effective dates shown below. The Policyholder acts for all listed subsidiaries, affiliates, divisions, branches and other similar entities in all matters of this policy. Such actions bind all listed subsidiaries, affiliates, divisions, branches and other similar entities.

MetLife and the Policyholder must agree to any change to this list. If change is needed, a policy amendment will be issued and attached to this policy to reflect the change to this Exhibit.

Name/Address of Subsidiary, Affiliate, Division, Branch and Other Similar Entity	**Effective Date**
NONE	

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166-0188

POLICY AMENDMENT

Group Policy No : **0119217**

Policyholder : **ClubCorp USA, Inc.**

Effective Date : **January 1, 2023**

Metropolitan Life Insurance Company ("MetLife"), a stock company, issues this amendment to change the following:

Under circumstances described in the Exhibits, Employees may be entitled to elect to continue their insurance if this policy ends. If on or after the date the policy would otherwise end there are certificates in effect under which one or more Employees have elected to continue their insurance in accordance with the terms and conditions specified in their certificates, this policy will be deemed to continue in effect but only with respect to those Employees.

This amendment is to be attached to and made a part of the policy. This amendment is subject to the terms and provisions of the policy.

To be completed by the Policyholder:

Signed at: _____ Date: _____
(City) (State)

_____ _____
(Signature of Policyholder's Legal Representative) (Print Name and Title of Legal Representative)

_____ _____
(Signature of Witness) (Print Name of Witness)

To be completed by Metropolitan Life Insurance Company:

Signed at: _____ Date: _____
(City) (State)

Michel Khalaf
President & CEO

Alan Hirschberg
Vice President
Supplemental Health Products

Summary Concerning Coverage, Limitations, and Exclusions under the Alaska Life and Health Insurance Guaranty Association Act

A resident of Alaska who purchases life insurance, annuities, or accident and health insurance should know that an insurance company licensed in the state to write these types of insurance is a member of the Alaska Life and Health Insurance Guaranty Association. The purpose of this association is to assure that a policyholder will be protected within statutory limits if a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the guaranty association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

The state law that provides for this safety net coverage is called the Alaska Life and Health Insurance Guaranty Association Act. The full text of the act can be found in AS 21.79.010 – 21.79.990. Provided below is a brief summary of this law's coverages, exclusions, and limits. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, an individual will be protected by the life and health insurance guaranty association if the individual lives in Alaska and holds a life or health insurance contract or annuity contract, or if the insured is insured under a group insurance contract issued by a member insurer. The beneficiary, payee, or assignee of an insured person is protected as well, even if a non-resident of Alaska.

EXCLUSIONS FROM COVERAGE

The association does not protect a person holding a policy if:

- the individual is eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state; or
- the policy is issued by an organization that is not a member of the Alaska Life and Health Insurance Guaranty Association.

The association does not provide coverage for:

- a policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- a policy of reinsurance (unless an assumption certificate was issued);
- an interest rate yield that exceeds an average rate;
- a dividend;
- a credit given in connection with the administration of a policy by a group contract holder;
- an employer's plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation.

- that part of an unallocated annuity contract not issued to a specific employee; union, association of natural persons benefit plan, or a government lottery;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer;
- certain obligations to provide a book value accounting guaranty for defined contribution benefit plan participants; or
- that part of a policy or contract that provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were issued by the same company, even if such contracts provided different types of coverages, the association will pay a maximum of:

- $300,000 in net life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;
- for health insurance benefits, $100,000 for coverages not defined as disability income, health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values;
- $300,000 for disability income insurance and long-term care insurance;
- $500,000 for health benefit plans;
- $250,000 in the present value of annuity benefits; including net cash surrender and net cash withdrawal value;
- with respect to a structured settlement annuity, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- $250,000 in the aggregate, of present-value annuity benefits, including net cash surrender and net cash withdrawal values with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. 401, 26 U.S.C.403(b), or 26 U.S.C. 457 and covered by an unallocated annuity contract, or to a beneficiary of the individual if the individual is deceased; or
- $5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts held by that contract holder, with respect to any one contract holder or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DA Cs, etc.) covered by the act: for unallocated annuities that fund government retirement plans under sections 401(k), 403(b), or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases the contract limits also apply.

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege violation of any provision of the Alaska Life and Health Insurance Guaranty Association Act must be filed with the Division of Insurance, 550 West Seventh Avenue, Suite 1560, Anchorage, Alaska, 99501-3567; telephone (907)269-7900. Financial information for an insurance company, if the insurance information is not proprietary, is available at the same address and telephone number. The guaranty association should not be contacted regarding the financial information of an insurance company.

The association is not an agency of the State of Alaska nor are there any guarantees by the State of Alaska regarding the payment of claims by the association. The guaranty association is not your insurance company.

Alaska Life and Health Insurance Guaranty Association
P.O. Box 220207
Anchorage, Alaska 99522-0207
(907)243-2311

Division of Insurance
550 West Seventh Avenue, Suite 1560
Anchorage, Alaska 99501-3567
(907)269-7900

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy and contract owners who live in this state and, in some cases, to keep coverage in force. Please note that the valuable extra protection provided by the member insurers through the Guaranty Association is limited. This protection is not a substitute for a consumers' careful consideration in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") provides coverage of claims under some types of policies or contracts if the insurer or health maintenance organization becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in the State of Arkansas. Other conditions may also preclude coverage.

The Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer or health maintenance organization and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy or health maintenance organization coverage.

You should not rely on availability of coverage under the Guaranty Association when selecting an insurer or health maintenance organization.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

The state law that provides for this safety net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"), which is codified at Ark. Code Ann. §§ 23-96-101, *et. seq.* Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act, nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state; or
- Their policy or contract was issued by a hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends, voting rights, and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employer plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to or in connection with benefit plans protected under the Federal Pension Benefit Corporation ("FPBC"), regardless of whether the FPBC is yet liable;
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by state or federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, claims for policy misrepresentations, and extra-contractual or penalty claims;
  or
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustee(s).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 in life insurance death benefits without regard to the number of policies and contracts there were with the same company, even if they provided different types of coverages. The Guaranty Association will pay a maximum of $500,000 in health benefits, provided that coverage for disability insurance benefits and long-term care insurance benefits shall not exceed $300,000. The Guaranty Association will pay $300,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits. These are limitations under which the Guaranty Association is obligated to operate prior to considering either its subrogation and assignment rights or the extent to which those benefits could be provided from assets of the impaired or insolvent insurer.

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of October 1, 2016, is $554,556. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact with of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

NOTICE OF
PROTECTION PROVIDED BY
LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

This notice provides a brief summary of the Life and Health Insurance Protection Association ("the Association") and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

In general, the maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website www.colifega.org or contact:

Colorado Life and Health *Insurance Protection Association* 201 Robert S. Kerr Ave. Suite 600 Oklahoma City, OK 73102 1-800-337-7796	*Colorado Division of Insurance* 1560 Broadway, Suite 850 Denver, CO 80202 (303) 894-7499

Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Colorado law, then Colorado law will control.

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

Residents of the District of Columbia should know that licensed insurers who sell health insurance, life insurance, and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association").

The purpose of the Guaranty Association is to provide statutorily-determined benefits associated with covered policies and contracts in the unlikely event that a member insurer is unable to meet its financial obligations and is found by a court of law to be insolvent. When a member insurer is found by a court to be insolvent, the Guaranty Association will assess the other member insurers to satisfy the benefits associated with any outstanding covered claims of persons residing in the District of Columbia. However, the protection provided through the Guaranty Association is subjected to certain statutory limits explained under "Coverage Limitations" section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep the coverage in-force, with no change in contractual rights or benefits.

Coverage

The Guaranty Association, established pursuant to the Life and Health Guaranty Association Act of 1992 ("Act"), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code Section 31-5401 *et seq*.), provides insolvency protection for certain types of insurance policies and contracts.

The insolvency protections provided by the Guaranty Association is generally conditioned on a person being 1) a resident of the District of Columbia and 2) the individual insured or owner under a health insurance, life insurance, or annuity contract issued by a member insurer, or insured under a group policy insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of District insureds are also covered under the Act, even if they reside in another state.

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

* The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or

* With respect to any one life, regardless of the number of policies, contracts, or certificates:
    - $300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
    - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
    - $300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
    - $300,000 for long-term care insurance benefits;
    - $300,000 for disability insurance benefits;
    - $500,000 for basic hospital, medical, and surgical insurance, or major medical insurance benefits;
    - $100,000 for coverage not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than $300,000 with respect to any one life ($500,000 in the event of basic hospital, medical, and surgical insurance, or major medical insurance).

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner of regardless of the number of policies owned.

Exclusions Examples

Policy or contract holders are not protected by the Guaranty Association if:

* They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insureds that live outside of that state);
* Their insurer was not authorized to do business in the District of Columbia; or
* Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not cover:

* Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
* Any policy of reinsurance (unless an assumption certificate was issued);

* Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
* Interest rate guarantees which exceed certain statutory limitations;
* Dividends, experience rating credits or fees for services in connection with a policy;
* Credits given in connection with the administration of a policy by a group contract holder; or
* Unallocated annuity contacts.

Consumer Protection

To learn more about the above referenced protections, please visit the Guaranty Association's website at www.dclifega.org. Additional questions may be directed to the District of Columbia Department of Insurance, Securities and Banking (DISB) and they will respond to questions not specifically addressed in this disclosure document.

Policy or contract holders with additional questions may contact either:

District of Columbia
Department of Insurance, Securities and Banking
1050 First St NE #801
Washington, DC 20002
Ph: (202) 727-8000
Fax: (202) 354-1085

District of Columbia
Life and Health Guaranty Association
1200 G Street, N.W.
Washington, DC 20005
Ph: (202) 434-8771
Fax: (202) 347-2990

Pursuant to the Act (D.C. Official Code Section 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and the amounts of coverage provided under the Act. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association would cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any rights established in any policy or contract or under the Act

HAWAII

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE HAWAII LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION ACT

Residents of Hawaii who purchase life insurance, annuities or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Hawaii Life and Disability Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Hawaii Life and Disability Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Hawaii. You should not rely on coverage by the Hawaii Life and Disability Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The Hawaii Life and Disability Insurance Guaranty Association
1132 Bishop Street, Suite 1590
Honolulu, Hawaii 96813

Department of Commerce & Consumer Affairs
Insurance Division
P.O. Box 3614
Honolulu, Hawaii 96811

The state law that provides for this safety-net coverage is called the Hawaii Life and Disability Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Hawaii Life and Disability Insurance Guaranty Association if they live in this state and hold a life or disability insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by the Guaranty Association if:

* they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state); or
* the insurer was not a member of the Guaranty Association. A nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or an insurance exchange are examples of nonmember insurers.

The Guaranty Association also does not provide coverage for:

* any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
* any policy of reinsurance (unless an assumption certificate was issued);
* interest rate yields that exceed an average rate;
* dividends;
* credits given in connection with the administration of a policy by a group contractholder;
* employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
* unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to pay out. The basic protections provided by the Association are:

- Life Insurance
  $300,000 in death benefits
  $100,000 in cash surrender or withdrawal values
- Health Insurance
  $500,000 in hospital, medical and surgical insurance benefits
  $300,000 in disability insurance benefits
  $300,000 in long-term care insurance benefits
  $100,000 in other types of health insurance benefits
- Annuities
  $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits and with regard to one owner or multiple non-group policies of life insurance.

NOTICE OF
PROTECTION PROVIDED BY
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, health maintenance organization or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage, pay claims, or otherwise provide protection in accordance with Illinois law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association per insured in each insolvency are:

- Life Insurance
  - $300,000 for death benefits
  - $100,000 for cash surrender or withdrawal values
- Health Insurance
  - $500,000 for health benefit plans*
  - $300,000 for disability insurance benefits
  - $300,000 for long-term care insurance benefits
  - $100,000 for other types of health insurance benefits
- Annuities
  - $250,000 for withdrawal and cash values

*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply with regard to health benefit plan benefits for which the maximum amount of protection is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health Insurance Guaranty Association
901 Warrenville Road, Suite 400
Lisle, Illinois 60532-4324

Illinois Department of Insurance
4th Floor
320 West Washington Street
Springfield, Illinois 62767

Insurance companies, health maintenance organizations and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company or health maintenance organization, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

The Association is not an insurance company or health maintenance organization. If you wish to contact your insurance company or health maintenance organization, please use the phone number found in your policy or contact the Illinois Department of Insurance at DOI.InfoDesk@illinois.gov.

NOTICE OF PROTECTION PROVIDED BY THE
INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This Notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies. (For the purposes of this Notice, the terms "insurance company" and "insurer" mean and include health maintenance organizations ("HMOs")).

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

Life Insurance

* $300,000 in death benefits
* $100,000 in net cash surrender or net cash withdrawal values

Health Insurance

* $500,000 for health plan benefits (see definition below)
* $300,000 in disability income and long-term care insurance benefits
* $100,000 in other types of health insurance benefits

Annuities

* $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2(o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this Notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
(317)636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
(317)232-2385

The policy or contract that this Notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

NOTICE OF PROTECTION PROVIDED BY IOWA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Iowa Life and Health Insurance Guaranty Association Act (the "Association") and the protection it provides for policyholders. This safety net was created under Iowa law, located at Iowa Code Chapter 508C, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, health insurance company or health maintenance organization becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Iowa law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance:

- $300,000 in death benefits
- $100,000 in net cash surrender and withdrawal values

Health Insurance:

- $500,000 for health benefit plans (see definition below)
- $300,000 in disability income protection insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits, including net cash surrender and withdrawal values

Annuities

- $250,000 in the present value of annuity benefits, including net cash surrender and withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000. Special rules may apply with regard to health benefit plans.

“Health benefit plan” is defined in the applicable Iowa law and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

Note: Certain policies and contracts may not be covered or fully covered. If coverage is available, it will be subject to substantial limitations and exclusions. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements under Iowa law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which the long-term rider relates.

To learn more about the Association and the protections it provides, as well as those relating to group contracts or retirement plans, please visit the Association's website at www.ialifega.org, or contact:

Iowa Life and Health Insurance
Guaranty Association
700 Walnut Street, Suite 1600
Des Moines, IA 50309
(515) 248-5712

Iowa Insurance Division
1963 Bell Ave, Suite 100
Des Moines, IA 50315
(515) 654-6600

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Ratings Inc., Moody's Investors Service, and S&P Global Ratings.

The Association is subject to the supervision of the Commissioner of the Iowa Insurance Division. Persons who desire to file a complaint to allege a violation of the laws governing the Association may contact the Iowa Insurance Division. State law provides that any suit against the Association shall be brought in the Iowa District Court in Polk County, Iowa.

Insurance companies and agents are not allowed by Iowa law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Iowa law, then Iowa law will control.

GENERAL PURPOSES AND LIMITATIONS OF THE
KANSAS LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION
K.S.A. 40-3001, et. seq.

DISCLAIMER

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS AND EXCLUSIONS, AND IS CONDITIONED UPON RESIDENCY IN THIS STATE. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU HAVE REGARDING THIS DOCUMENT.

Kansas Life and Health Insurance
Guaranty Association
3745 SW Wanamaker Road, Suite C
Topeka, KS 66610

Kansas Insurance Department
420 SW 9th Street
Topeka, KS 66612

This is a brief summary of the Kansas Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

- Life Insurance
  $300,000 in death benefits
  $100,000 in cash surrender or withdrawal values

- Health Insurance
  $500,000 in hospital, medical and surgical insurance benefits
  $300,000 in disability insurance benefits
  $300,000 in long-term care insurance benefits
  $100,000 in other types of health insurance benefits

- Annuities
  $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits, as well as certain aggregate limits.

Summary of the Louisiana Life and Health Insurance Guaranty Association Law and Notice Concerning Coverage Limitations and Exclusions

Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are required by law to be members of the Louisiana Life and Health Insurance Guaranty Association (LLHIGA). The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. *COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY*. Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA
P.O. Box 3337
Baton Rouge, Louisiana 70821

Department of Insurance
P.O. Box 94214
Baton Rouge, Louisiana 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the Law), and is set forth at R.S. 22:2081 *et seq*. The following is a brief summary of this Law's coverages, exclusions and limits. This summary does not cover all provisions of the Law; nor does it in any way change any person's rights or obligations under the Law or the rights or obligations of LLHIGA.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a covered life, health, or annuity policy, plan or contract issued by an insurer (including a health maintenance organization) authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well even if they live in another state unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the Law are applicable.

EXCLUSIONS FROM COVERAGE

A person who holds a covered life, health, or annuity policy, plan or contract is not protected by LLHIGA if:

(1) He is eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
(2) The insurer was not authorized to do business in this state;
(3) His policy was issued by a profit or nonprofit hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA also does not provide coverage for:

(1) Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
(2) Any policy of reinsurance (unless an assumption certificate was issued);
(3) Interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
(4) Dividends, premium refunds, or similar fees or allowances described under the Law;
(5) Credits given in connection with the administration of a policy by a group contract holder;
(6) Employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;
(7) Unallocated annuity contracts (which give rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans qualified under section 403(b) of the United States *Internal Revenue Code* (26 U.S.C. §403(b)).
(8) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the Law;
(9) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part A Coverage", "Medicare Part B Coverage", "Medicare Part C Coverage", "Medicare Part D Coverage" or "Medicaid" and any regulations issued pursuant to those parts;
(10) Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:

(1) LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or insolvent insurer.
(2) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.
(3). For any one insured life, regardless of the number of policies and contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any one individual.

NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty Corporation (the Corporation) and the protection it provides for policyholders and contract holders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

The Corporation was established to provide protection in the unlikely event that your health maintenance organization or your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Corporation are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance or Health Benefit Plans
  - $500,000 for coverage provided by health benefit plans
  - $300,000 for disability insurance
  - $300,000 for long-term care insurance
  - $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above
- Annuities
  - $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
  - With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values

- The maximum amount of protection for each individual, regardless of the number of policies or contracts, is:
  - $300,000 in aggregate for all types of coverage listed above, with the exception of coverage provided by health benefit plans
  - $500,000 in aggregate for coverage provided by health benefit plans

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

To learn more about the above protections, please visit the Corporation's website at www.mdlifega.org, or contact:

Maryland Life and Health Insurance Guaranty Corporation
6210 Guardian Gateway
Suite 195APG
Aberdeen, Maryland 21005
410-248-0407

Insurance companies, health maintenance organizations and insurance producers are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance or a health benefit plan. When selecting an insurance company or health maintenance organization, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
200 Park Avenue
New York, New York 10166
1-800-638-5433

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer who issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer. In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
3300 Wells Fargo Center
90 South 7th Street
Minneapolis, MN 55402
Phone: 612-322-8713
Fax: 402-474-5393

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under Section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992; are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available.

The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment. THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION. THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT.

THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

NOTICE OF PROTECTION PROVIDED BY
MISSISSIPPI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Mississippi Life and Health Insurance Guaranty Association (the "Association") and the protection it provides for policyholders. This safety net was created by Mississippi law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurer becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Mississippi law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

Life Insurance

- $300,000 in death benefits
- $100,000 in net cash surrender and net cash withdrawal values

Health Insurance

- $500,000 for health benefit plans (see definition below)
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans.

"Health benefit plan" is defined in Miss. Code Ann. § 83-23-209 and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Mississippi law.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, limitations and exclusions, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mslifega.org, or contact:

Mississippi Life and Health Insurance
Guaranty Association
330 North Mart Plaza
Jackson, MS 39206-5327
601-981-0755

Mississippi Insurance Department
Woolfolk Building
501 N. West Street, Suite 1001
Jackson, MS 39201
601-359-3569

EN-GUAR-12-20 MS

To file a complaint or seek information about the financial condition of an insurer, contact the Mississippi Insurance Department.

Your insurer is required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of insurance.

NOTICE OF PROTECTION PROVIDED BY MISSOURI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a *brief summary* of the Missouri Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Missouri law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Missouri law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations (HMOs).) The basic protections provided by the Association are as follows:

* Life Insurance
* $300,000 in death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values
* Health Insurance
* $500,000 for health benefit plans
* $300,000 in disability insurance benefits
* $300,000 in long-term care insurance benefits
* $100,000 in other types of health insurance benefits
* Annuities
* $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

* $300,000 in aggregate for all types of coverage listed above, with the exception of health benefit plans

* $500,000 in aggregate for health benefit plans

* $5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons

“Health benefit plan” is defined in section 376.718, RSMo.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Missouri law.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the basic life insurance policy or annuity contract to which it relates.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mo-iga.org, or contact:

Missouri Life and Health Insurance Guaranty Association
2210 Missouri Boulevard
Jefferson City, Missouri 65109
Ph.: 573-634-8455
Fax: 573-634-8488

Missouri Department of Commerce and Insurance
301 West High Street, Room 530
Jefferson City, Missouri 65101
Ph.: 573-522-6115

Insurance companies and agents are not allowed by Missouri law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Missouri law, then Missouri law will control.

NOTICE OF
PROTECTION PROVIDED BY
MONTANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Montana Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders.

The Association was established under Montana law to provide protection in the unlikely event that a life, annuity or health insurance issuer becomes financially unable to meet its obligations and is placed into liquidation. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Montana law, with funding from assessments paid by other insurance companies.

In the event a company is placed into liquidation, benefits provided by the Association are payable according to the insurance policy or certificate, and subject to the following maximum limits:

- Life Insurance - $300,000 in death benefits, but limited to $100,000 in cash surrender and net cash withdrawal values.
- Health Insurance
  - $500,000 in health insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 present value, including net cash surrender and net cash withdrawal values

The maximum amount of protection is $300,000 in benefits with respect to any one life regardless of the number of policies or contracts, except with respect to the $500,000 maximum in health insurance benefits but not including disability, long term care or other types of health insurance benefits.

Note: <u>Other restrictions to coverage apply.</u> Certain policies and contracts may not be covered or fully covered.
For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Montana law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's web site at www.mtlifega.org or contact:

Montana Life and Health Insurance Guaranty Association PO Box 8247 Missoula, MT 59807 877-678-1048 or administrator@mtlifega.org	Office of the Montana State Auditor Commissioner of Securities and Insurance 840 Helena Ave. Helena, MT 59601 406-444-2040

IF YOUR INSURANCE COMPANY IS IN GOOD STANDING AND NOT IN LIQUIDATION, PLEASE DIRECT QUESTIONS ABOUT YOUR POLICY TO YOUR INSURANCE COMPANY!

Insurance companies and agents are not allowed by Montana law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage.

If there is any inconsistency between this notice and Montana law, then Montana law will control.

NOTICE OF PROTECTION PROVIDED BY NEVADA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

Effective On or Before July 1, 2022

This notice provides a **brief summary** regarding the protections provided to policyholders by the Nevada Life and Health Insurance Guaranty Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies and health maintenance organizations licensed in Nevada to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is limited and is *not* a substitute for consumers' care in selecting insurers. **Your policy or contract may not be covered, and if covered, there are substantial coverage limitations and exclusions. Further, coverage is dependent on continued residence in Nevada.** Below is a brief summary of the coverages, exclusions, and limits provided by the Association. This summary does not cover all provisions of the law, and the law may change.

COVERAGE

Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in Nevada at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in Nevada.

Amounts of Coverage

For any one life, per company, the coverage protections provided by the Association shall not exceed:

- **Life Insurance**
  - Death benefits: $300,000
  - Cash surrender or withdrawal values: $100,000
- **Annuities and Structured Settlement Annuities**
  - Present value of annuity benefits and structured settlement annuities, including cash surrenders or withdrawal values: $250,000
  - Participants in a government retirement plan covered by an unallocated annuity as described by NRS 686.C.035: $250,000.
- **Health Insurance**
  - Disability Income and long-term care insurance, including net cash surrender values: $300,000
  - Health Benefit Plan: $500,000
  - Health insurance, other than disability income, long-term care insurance or Health Benefit Plan: $100,000

Please note that the maximum protection provided by the Association to an individual for all life insurance, annuities, and structured settlement annuities with one insurer is $300,000; or for all life insurance, annuities, structured settlement annuities, and benefits for health benefit plans with one insurer, $500,000, regardless of the number of policies or contracts covering the individual.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The following policies and persons are examples of those excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Nevada when it issued the policy or contract
- A policy or contract issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or an organization that is only licensed to issue charitable gift annuities
- Persons provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual except for annuities owned by a governmental retirement plan established under section 401, 403(b), or 457 of the Internal Revenue Code
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued ● Interest rate yields exceed an average rate

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NOTICES

Member insurers or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. The member insurer and its agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of insurance or coverage offered by a health maintenance organization. You may file a complaint with the Nevada Insurance Commissioner if you believe any provision of the Nevada Life and Health Insurance Guarantee Association law has been violated. To learn more about coverage provided by the Association, please visit the Association's website at www.nvlifega.org, or contact either of the following:

Nevada Life and Health Insurance
Guaranty Association
2377 Gold Meadow Way, Suite 100
Gold River, CA 95670

Nevada Division Insurance
Department of Business and Industry
1818 E. College Pkwy., Suite 103
Carson City, NV 89706

When selecting an insurer, you should not rely on Association coverage. If there is any inconsistency between this notice and Nevada law, Nevada law will control.

SUMMARY OF THE NEW HAMPSHIRE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT of 2019 (RSA 408-F) (the Act) AND **NOTICE CONCERNING COVERAGE AND LIMITATIONS**

SUMMARY:

This notice provides a brief summary of the purpose of the New Hampshire Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under New Hampshire law, which determines who and what is covered and the amounts of coverage. This summary does not cover all provisions of the law and it does not in any way change one's rights or obligations under the Act or the rights or obligations of the Association.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with New Hampshire law, with funding from assessments paid by other insurance companies, including health maintenance organizations (HMOs).

DISCLAIMER:

The Association may not cover your policy or contract or, if coverage is available, it may be subject to substantial limitations and exclusions and conditioned on continued residence in the state.

This protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable and consumers should not rely on coverage under this Act when selecting an insurer or HMO. The valuable protection through the Guaranty Association is not unlimited.

COVERAGE:

Generally, individuals will be protected by the New Hampshire Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance policy or an annuity contract, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, assignees or payees of insured persons are protected as well, even if they live in another state.

Coverage provided under the current, amended Act may be different from coverage provided prior to 2020, as coverage is determined by the governing Act in effect on the date that the Association becomes obligated.

BASIC LIMITS ON AMOUNT OF COVERAGE:

The Act limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurance company would owe under a policy or contract.

The basic protections provided by the Association are limited to:

- **Life Insurance**
  - $300,000 in death benefits
  - $100,000 in cash surrender and withdrawal values

- **Health Insurance**
  - $500,000 for health benefit plans (see definition below)
  - $300,000 in disability (income) insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- **Annuities**
  - $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

With respect to any one life, the Association will pay a maximum of $300,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverages, except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance, in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual.

"Health benefit plan" is defined in RSA 408-F:4,VI and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or an annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

NOTE: Certain policies and contracts may not be covered or may not be fully covered. For example, coverage does not extend to a portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy.

This information is provided by:

New Hampshire Life and Health Insurance Guaranty Association
10 Chestnut Drive, Unit B
Bedford, NH 03110
(603) 472-3734
www.nhlifega.org

New Hampshire Department of Insurance
21 South Fruit Street, Suite 14
Concord, NH 03301
(603) 271-2261
www.nh.gov/insurance/

February 2020

NOTICE

NEW JERSEY LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you had assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The New Jersey Life and Health Insurance Guaranty Association
521 Newman Springs Road, Suite 22
Lincroft, NJ 07738

State of New Jersey
Department of Banking and Insurance
20 West State Street
P.O. Box 325
Trenton, NJ 08625

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Insurance Guaranty Association Act, N.J.S.A. 17B:32A-1, et seq. (the "Act").

COVERAGE

The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than $500,000 in life insurance death benefits and present value annuity benefits, including net cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than $100,000 in cash surrender values for annuity benefits, $500,000 in life insurance death benefits or $500,000 in present value of annuities - again no matter how many policies and contracts that were with the same company, and no matter how many different types of coverages.

The Association will not pay more than $2,000,000 in benefits to any one contractholder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.

NEW MEXICO

NOTICE OF
PROTECTION PROVIDED BY
NEW MEXICO LIFE INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the New Mexico Life Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under New Mexico law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with New Mexico law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance
- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance
- $500,000 in hospital, medical and surgical insurance benefits
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities
- $250,000 in present value of annuity benefits

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000 ($500,000 for hospital, medical and surgical insurance policies).

Note to benefit plan trustees or other holders of unallocated annuities covered under the act: For unallocated annuities that fund certain governmental retirement plans, the limit is $250,000 in present value of annuity benefits per plan participant. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held or number of persons covered.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under New Mexico law.
To learn more about the above protections, please visit the Association's website at www.nmlifega.org, or contact:

New Mexico Life Insurance Guaranty Association PO Box 2880 Santa Fe, NM 87504-2880 505-820-7355	Insurance Division Public Regulation Commission PO Box 1269 Santa Fe, NM 87504-1269 888-427-5772

Insurance companies and agents are not allowed by New Mexico law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and New Mexico law, then New Mexico law will control.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies and Health Maintenance Organizations (HMOs) licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer or HMO becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted *in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
4441 Six Forks Rd Ste 106-153
Raleigh, NC 27609-5729
https://www.nclifega.org/

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange;
- They acquired rights to receive payments through a structured settlement factoring transaction.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contractholder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
(2) Except as provided in (3), (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
(3) The guaranty association will pay a maximum of $500,000 with respect to a health benefit plan.
(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

NOTICE OF PROTECTION PROVIDED BY THE NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the North Dakota Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under North Dakota law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with North Dakota law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The protections provided by the Association are based on contract obligations up to the following amounts:

1. Life Insurance

    a. $300,000 in death benefits

    b. $100,000 in cash surrender or withdrawal values

2. Health Insurance

    a. $500,000 for health benefit plans (see definition below)

    b. $300,000 in disability income insurance benefits

    c. $300,000 in long-term care insurance benefits

    d. $100,000 in other types of health insurance benefits

3. Annuities

    a. $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of type of coverage is $300,000; however, may be up to $500,000 with regard to health benefit plans.

"Health benefit plan" is defined in North Dakota Century Code Section 26.1-38.1-02(10) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance, and long-term care insurance (LTCI).

Benefits provided by a long-term care (LTC) rider to a life insurance policy of annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. If coverage is available, it will be subject to substantial limitations. There are also various residency requirements and other limitations under North Dakota law. To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ndlifega.org or contact:

North Dakota Life and Health Insurance Guaranty Association
P.O. Box 2422
Fargo, ND 58108

North Dakota Insurance Department
600 East Boulevard Avenue, Dept. 401
Bismarck, ND 58505

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege a violation of any provision of the Life and Health Insurance Guaranty Association Act must be filed with the North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, North Dakota 58505; telephone (701) 328-2440. Financial information for an insurance company, if the information is not proprietary, is available at the same address and telephone number and on the Insurance Department website at www.nd.gov/ndins.

Insurance companies and agents are not allowed by North Dakota law to use the existence of the Association or its coverage to sell, solicit or induce you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and North Dakota law, then North Dakota law will control.

Notice Concerning Coverage Limitations and Exclusions under the Ohio Life and Health Insurance Guaranty Association Act

Residents of Ohio who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.*

Ohio Life and Health Insurance Guaranty Association
5005 Horizons Drive, Suite 200
Columbus, OH 43220

Ohio Department of Insurance
50 West Town Street
Third Floor-Suite 300
Columbus, OH 43215

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract; if they are insured under a group insurance contract, issued by a member insurer; or if they are the payee or beneficiary of a structured settlement

annuity contract. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000, except as specified below, no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. The association will not pay more than $100,000 in cash surrender values, $500,000 in major medical insurance benefits, $300,000 in disability or long-term care insurance benefits, $100,000 in other health insurance benefits, $250,000 in present value of annuities, or $300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages, the association will pay a maximum of $300,000, except for coverage involving major medical insurance benefits, for which the maximum of all coverages is $500,000.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DA Cs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under §§401, 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual, except as noted above. For covered unallocated annuities that fund other plans, a special limit of $1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

For more information about the Ohio Life & Health Insurance Guaranty Association, visit our website at: www. olhiga.org.

As of 11/15/2018

NOTICE OF
PROTECTION PROVIDED BY
OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

- Life Insurance
    - o $300,000 in death benefits
    - o $100,000 in cash surrender or withdrawal values
- Health Insurance
    - o $500,000 for health benefit plans (see definition below)
    - o $300,000 in disability [income] insurance benefits
    - o $300,000 in long-term care insurance benefits
    - o $100,000 in other types of health insurance benefits
- Annuities
    - o $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except with regard to health benefit plans for which the maximum amount of protection is $500,000 for each individual.

"Health benefit plan" is defined in 36 O.S. §2024(7) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Oklahoma law.

To learn more about the above protections, please visit the Association's website at www.oklifega.org, or contact:

Oklahoma Life & Health Insurance Guaranty Association
201 Robert S. Kerr, Suite 600
Oklahoma City, OK 73102

Oklahoma Department of Insurance
400 NE 50th Street
Oklahoma City, OK 73105
1-800-522-0071 or (405) 521-2828

Insurance companies and agents are not allowed by Oklahoma law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Oklahoma law, then Oklahoma law will control.

NOTICE OF PROTECTION PROVIDED BY
PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** regarding the protections provided to policyholders by the Pennsylvania Life and Health Insurance Guaranty Association ("the Association"). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to $300,000 (or $500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:
o Up to $300,000 in death benefits including up to $100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):
o Up to $500,000 for health benefit plans, with some exceptions.
o Up to $300,000 for disability income benefits.
o Up to $300,000 for long-term care insurance benefits.
o Up to $100,000 for all other types of health insurance.

Individual annuities
o Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;

- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contractholder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract
- If the person is provided coverage by the guaranty association of another state
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
www.insurance.pa.gov

The summary information provided by this notice and on the Association's web site do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's web site are for general information purposes and should not be relied upon as legal advice.

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company

SUMMARY

COVERAGE, LIMITATIONS AND EXCLUSIONS UNDER RHODE ISLAND LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT ("Act")

A resident of Rhode Island who purchases life insurance, annuities, long-term care, or accident and health insurance should know that an insurance company licensed in Rhode Island to write these types of insurance is a member of the Rhode Island Life and Health Insurance Guaranty Association ("Association"). The purpose of the Association is to assure that a policyholder will be protected within the statutory limits, if a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will, within the statutory limits, pay the claims of insured persons who live in this state, and in some cases, keep coverage in force. However, the protection provided through the Association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

The Rhode Island Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in this state. Other conditions may also preclude coverage.

The Life and Health Insurance Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association when selecting an insurer.

RHODE ISLAND LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
235 Promenade Street, #426
Providence, RI 02908
TEL (401) 273-2921

RHODE ISLAND DIVISION OF INSURANCE
1511 Pontiac Avenue
Cranston, RI 02920
(401) 462-9520

The full text of the state law that provides for this safety net coverage, Rhode Island Life and Health Insurance Guaranty Association Act, ("the Act"), can be found beginning at R.I. Gen Laws section 27-34.3-3. A brief summary of the Act is provided below. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations or those of the Association under the Act.

COVERAGE

Generally, individuals will be protected by the Association if the individual lives in Rhode Island and: Holds a life or health insurance contract, long-term care contract or annuity contract; or is insured under a group insurance contract issued by a member insurer. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live elsewhere.

EXCLUSIONS FROM COVERAGE

The Association does NOT protect a person holding a policy if:

- the individual is eligible for protection under a similar law of another state;
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization that is not a member of the Association;
- the policy was issued by a nonprofit hospital or medical service organization (such as, the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments or by an insurance exchange.

The Association does not provide coverage for:

- a policy or portion of a policy not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus; a policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed a rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- an employer's plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer.
- a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D) or any regulations issued pursuant thereto.

LIMITATIONS ON COVERAGE

The Act limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurer would have owed under a policy or contract. Also for any one insured life, no matter how many policies or contracts were in force with the same insurer, the Association will pay no more than:

- $300,000 in life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;
- $100,000 for health insurance benefits, coverages not defined as disability, basic hospital, medical, and surgical, major medical insurance, or long-term care insurance including any net cash surrender and net cash withdrawal values;
- $300,000 for disability insurance;
- $300,000 for long-term care insurance;
- $500,000 for basic hospital, medical, and surgical insurance;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal value;

- $250,000 in present value per payee with respect to a structured settlement annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- $250,000, in the aggregate, in present value of annuity benefits, including net cash surrender and net cash withdrawal values, with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. §§401, 403(b), or 457 covered by an unallocated annuity contract, or the beneficiaries of each such individual if deceased;
- $5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund government retirement plans under sections 401, 403(b), or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the Association be liable to spend more than $300,000 in the aggregate per individual except hospital insurance up to $500,000 per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, the contract limits also apply.

These general statements as to Limitations on Coverage are only summaries of the law. The actual limitations are set forth in R.I. Gen Laws section 27-34.3-3.

Any alleged violations of the provisions of the Rhode Island Life and Health Insurance Guaranty Association Act may be reported to the Rhode Island Division of Insurance at the address and telephone number above.

This information is provided by: The Association and by the Division of Insurance, whose respective addresses are provided in the Disclaimer, above.

Summary of the South Carolina Life and Accident and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of South Carolina who hold life insurance, annuities, or health insurance policies should know that the insurance companies and health maintenance organizations (HMOs) licensed in this state to write these types of insurance are required by law to be members of the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA). The purpose of SCLAHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, SCLAHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through SCLAHIGA is limited. Consumers should shop around for insurance coverage and exercise care and diligence when selecting insurance coverage.

Disclaimer

Under South Carolina law, the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA) may provide coverage of certain direct life insurance policies, accident and health insurance policies, annuity contracts and contracts supplemental to life, accident and health insurance policies and annuity contract claims (covered claims) if the insurer becomes impaired or insolvent. South Carolina law does not require the SCLAHIGA to provide coverage for every policy. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.**

Coverage is generally conditioned upon residence in this state. Other conditions that may preclude or exclude coverage are described in this notice. Even if coverage is provided, there are significant limits and exclusions. Please read the entire notice for further details on limitations and exclusions.

Insurance companies and insurance agents are prohibited by law from using the existence of the SCLAHIGA or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under SCLAHIGA when selecting an insurer. The South Carolina Life and Accident and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

If you think the law has been violated, you may file a written complaint with the SCLAHIGA or the South Carolina Department of Insurance at the addresses listed below:

South Carolina Life and Accident and Health Insurance Guaranty Association
Attention: Executive Director
P.O. Box 8625
Columbia, SC 29202

South Carolina Department of Insurance
Attention: Office of Consumer Services
1201 Main Street, Suite 1000
Columbia, SC 29201
Electronic complaint submission via
www.doi.sc.gov/complaint

Please attach copies of all pertinent documentation. You may submit a written complaint or a complaint electronically to the Department through submission of the electronic form on the Department's website at www.doi.sc.gov/complaint. You should receive a response to your complaint within 10 days.

This safety-net coverage is provided for in the South Carolina Life and Accident and Health Insurance Guaranty Association Act (the Act). The following summary of the Act's coverages, exclusions and limits does not cover all provisions of the Act; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the SCLAHIGA.

COVERAGE

Generally, individuals will be protected by the SCLAHIGA if they live in this state and hold a covered life, accident, health or annuity policy, plan or contract issued by an insurer (including a health maintenance organization) authorized to conduct business in South Carolina. The beneficiaries, payees or assignees of insured persons may also be protected if they live in another state unless circumstances described under the Act exclude coverage.

EXCLUSIONS FROM COVERAGE

Persons who hold a covered life, accident, health or annuity policy, plan or contract are r1ot protected by SCLAHIGA if:

- They are eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
- The insurer was not authorized to do business in this state; or
- They acquired rights to receive payments through a structured settlement factoring agreement.

SCLAHIGA also does not provide coverage for:

- A portion of a policy or contract or part thereof not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;
- A policy or contract of reinsurance, unless assumption certificates have been issued;
- Interest rate or crediting rate yields or similar factors employed in calculating value changes that exceed an average rate;
- Any policy or contract issued by assessment mutuals, fraternals, and nonprofit hospital and medical service plans;
- Benefits payable by an employer, association or other person under: (a) a multiple employer welfare arrangement; (b) a minimum premium group insurance plan; (c) a stop-loss group insurance plan; or (d) an administrative services contract;
- A portion of a policy or contract to the extent that it provides for (a) dividends or experience rating credits; (b) voting rights; or (c) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
- A portion of a policy or contract to the extent that the assessments required by Section 38-29-80 with respect to the policy or contract are preempted by federal or state law;
- An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation: (a) Claims based on marketing materials; (b) Claims based on side letters, riders or other documents that were issued by *the* member insurer without meeting applicable policy or contract form filing or approval requirements; (c) Misrepresentations of or regarding policy or contract benefits; (d) Extra-contractual claims; or (e) A claim for penalties or consequential or incidental damages;
- An unallocated annuity contract;
- A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C or Dor Medicaid; or
- Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The South Carolina Life and Accident and Health Insurance Guaranty Association Act also limits the amount that SCLAHIGA is obligated to pay for covered claims. The benefits for which SCLAHIGA may become liable shall in no event exceed the lesser of the following:

- With respect to one life, regardless of the number of policies or contracts: $300,000 in life insurance death benefits, or not more than $300,000 in net cash surrender and net cash withdrawal values for life insurance;
- For health insurance benefits: (a) $300,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values; (b) $300,000 for disability income insurance; (c) $300,000 for long-term care insurance; (d) $500,000 for health benefit plans; or
- $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE SOUTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of South Dakota who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the South Dakota Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policy owners, contract owners, and certificate owners will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Guaranty Association does not provide coverage for all types of life, health, or annuity benefits, and the Guaranty Association may not provide coverage for this policy or contract. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in South Dakota. You should not rely on coverage by the South Dakota Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy or contract.

Coverage is NOT provided for your policy or contract for any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any kind of insurance policy or contract.

South Dakota Life and Health Insurance Guaranty Association
Charles D. Gullickson, Executive Director
206 West 14th Street
Sioux Falls, South Dakota 57104
Tel. (605) 336-0177
www.sdlifega.org

South Dakota Division of Insurance
124 S. Euclid Avenue, 2nd Floor
Pierre, South Dakota 57501
Tel. (605) 773-3563
www.dlr.sd.gov/insurance

The state law that provides for this safety-net coverage is called the South Dakota Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

(**please see next page**)

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are an insured certificateholder under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Coverage is also provided by the Guaranty Association to persons eligible to receive payment under structured settlement annuities who are residents of this state and, under certain conditions, such persons even if they are not a resident of this state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies or contracts are **not** protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy or contract was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy owner, contract owner, or certificate owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **not** provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy or contract by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals);
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer; or policies providing health care benefits for Medicare Parts C or D coverage.

LIMITS ON AMOUNT OF COVERAGE

The Guaranty Association in no event will pay more than what an insurance company would owe under a policy or contract. In addition, state law limits the amount of benefits the guaranty association will pay for any one insured life, and no matter how many policies or contracts there are with the same company, as follows: (i) for life insurance, not more than $300,000 in death benefits and not more than $100,000 in net cash surrender and net cash withdrawal values; (ii) for health benefit plans, not more than $500,000, but not more than $300,000 for disability insurance and long term care insurance, and not more than $100,000 for other types of health insurance; and (iii) for annuities, not more than $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values. However, in no event will the Guaranty Association be obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to health benefit plans, for which the aggregate liability of the guaranty association may not exceed $500,000. These general statements of the limits on coverage are only summaries and the actual limitations are set forth in South Dakota law.

(**please see next page**)

ADDITIONAL INFORMATION

The statutes which govern the Guaranty Association are contained in SDCL Chapter 58-29C. Additional information about the Guaranty Association may be found at www.sdlifega.org, which contains a link to SDCL Chapter 58-29C.

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as A.M. Best Company, Fitch Ratings, Moody's Investors Service, Inc., and Standard & Poor's. Additional information about financial rating agencies may be obtained by clicking on "Useful Links" on the website of the South Dakota Division of Insurance at www.dlr.sd.gov/insurance.

The Guaranty Association is subject to supervision and regulation by the director of the South Dakota Division of Insurance. Persons who desire to file a complaint to allege a violation of the statutes governing the Guaranty Association may contact the Division of Insurance. State law provides that any suit against the Guaranty Association shall be brought in Hughes County, South Dakota.

NOTICE CONCERNING COVERAGE UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Insurance companies and health maintenance organizations (HMOs) licensed in this state to write life insurance, annuities or health insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to provide a safety-net of coverage, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverage, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, HMO contract, or an annuity, or if they are insured under a group insurance contract issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state);

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

(2) any policy of reinsurance (unless an assumption certificate was issued);

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contractholder;

(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

(7) unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - $300,000
- life insurance cash surrender value - $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000

- present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000

- health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000

- health insurance benefits for companies declared insolvent on or after January 1, 2010:

    - $100,000 for limited benefits and supplemental health coverages

    - $300,000 for disability and long term care insurance

    - $500,000 for basic hospital, medical and surgical insurance or major medical insurance

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NOTE

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Insurance Guaranty Association
P.O. Box 190434

Nashville, TN 37219
Website: www.tnlifega.org

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

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How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.

- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.

- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.

- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.

- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 515 Congress Avenue, Suite 1875 Austin, TX 78701 1-800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

NOTICE OF PROTECTION PROVIDED BY THE UTAH LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This disclaimer provides a **brief summary** of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. The safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with the funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
  - $500,000 in death benefits
  - $200,000 in cash surrender or withdrawal values
- Accident and Health Insurance
  - $500,000 for health benefit plans
  - $500,000 in disability income insurance benefits
  - $500,000 in long-term care insurance benefits
  - $500,000 in other types of health insurance benefits
- Annuities
  - $250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to health benefit plans.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

Benefits provided by a long-term care rider to a life insurance or annuity contract shall be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, please visit the Association's website at www.ulhiga.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
32 West 200 South, #150
Salt Lake City, UT 84101
(801) 320-9955

Utah Insurance Department
State Office Bldg., Rm. 3110
Salt Lake City, UT 84114
(801) 538-3800

NOTICE OF
PROTECTION PROVIDED BY
VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender and withdrawal values

- Health Insurance
  - $500,000 for health benefit plans
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of accident and sickness insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for health benefit plans, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P. O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://scc.virginia.gov/boi/index.aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

SUMMARY OF THE
WEST VIRGINIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT
(Effective July 1, 2019)

Residents of West Virginia who purchase life insurance, annuities or health insurance should know that the insurance companies and health maintenance organizations licensed in this state to write these types of insurance are members of the West Virginia Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policy and contract owners, certificate holders and enrollees of covered policies and contracts will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurers for the money to pay the claims of covered persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these member insurers through the Guaranty Association is not unlimited, however, and, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The West Virginia Life and Health Insurance Guaranty Association may not provide coverage for this policy or contract. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in West Virginia. You should not rely on coverage by the West Virginia Life and Health Insurance Guaranty Association in selecting an insurance company or health maintenance organization or in selecting an insurance policy or contract. For a complete description of coverage, consult Article 26A, Chapter 33 of the West Virginia Code.

Coverage is NOT provided for any portion OF YOUR CONTRACT that is not guaranteed by the insurer or for which you have assumed the risk.

Insurance companies and health maintenance organizations or their agents are required by law to give or send you this notice. *However, insurance companies, health maintenance organizations and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy or health maintenance organization coverage.*

The Guaranty Association or the West Virginia Insurance Commission will respond to questions you may have which are not answered by this document. Policyholders with additional questions may contact:

West Virginia Life and Health Insurance Guaranty Association
P.O. Box 816
Huntington, West Virginia 25712

West Virginia Insurance Commissioner
Consumer Services Division
900 Pennsylvania Avenue
P. O. Box 50540
Charleston, West Virginia 25305 0540
(304) 558-3386
Toll Free 1-888-879-9842
TDD 1-800-435-7381

The state law that provides for this safety-net coverage is called the West Virginia Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the West Virginia Life and Health Insurance Guaranty Association if they live in West Virginia and hold a life,r health or annuity policy, plan or contract, or if they are insured under a group life, health or annuity policy, plan or contract, issued by a member insurer. Member insurer also includes non-profit service corporations (W. Va. Code §33-24), health care corporations (W. Va. Code §33-25) and health maintenance organizations (W. Va. Code §33-25A). The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies, plans or contracts are not protected by this Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent member insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The member insurer was not authorized to do business in this state;
- The policy, plan or contract was issued at a time when the member insurer was not licensed or authorized to do business in the state;
- The policy, plan or contract was issued by a fraternal benefit society, mandatory state pooling plan, a mutual protective association or similar plan in which the policy, plan or contract holder is subject to future assessments, an insurance exchange, an organization that has a certificate or license limited to the issuance of charitable gift annuities or any entity similar to the above.

The Guaranty Association also does not provide coverage for:

- Any policy, plan or contract, or portion of a policy, plan or contract that is not guaranteed by the member insurer or for which the individual or contract holder has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends;
- Credits given in connection with the administration of a policy, plan or contract by a group contract holder;
- Employer or association plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured, including:
    i. multiple employer welfare arrangement;
    ii. minimum premium group insurance plan;
    iii. stop loss group insurance plan; or
    iv. administrative services only contract;
- Any unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension guaranty corporation;
- Any portion of any unallocated contract that is not issued to or in connection with a specific employee, union or association's benefit plan or a governmental lottery;
- Any policy, plan or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C and D or Medicaid;
- An obligation that does not arise under the written terms of the policy, plan or contract, including claims based on marketing materials, claims based on side letters or riders not approved by the Commissioner, misrepresentations regarding policy benefits, extracontractual claims or claims for penalties or consequential or incidental damages;
- A contractual agreement that establishes the member insurer’s obligation to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or trustee, which is not an affiliate of the insurer;

- Structured settlement annuity benefits, the rights to which have been transferred by the payee or beneficiary in a structured settlement factoring transaction.

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the member insurer would owe under a policy, plan or contract. Also for any one insured life, regardless of the number of policies, plans or contracts, the Guaranty Association will only pay:

- $300,000 in life insurance benefits, but no more than $100,000 in net cash surrender and net cash withdrawal values;
- $300,000 for disability income insurance;
- $300,000 for long term care insurance;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;
- $500,000 for health benefit plans (W. Va. Code §33-26A-5(10)); and
- $100,000 for all other types of accident and sickness insurance coverages not defined as disability income insurance, long term care insurance, or health benefit plans.

Also for any one insured life, the Guaranty Association will only pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company - for all policies or contracts other than health benefit plans, in which case the aggregate limit shall not exceed $500,000 with respect to any one individual.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund governmental retirement plans under §§ 401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, per participating individual. In no event shall the Guaranty Association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

NOTICE OF
PROTECTION PROVIDED BY
WYOMING LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Wyoming Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Wyoming law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company or health maintenance organization becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Wyoming law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association are:

* Life Insurance

  - $300,000 in death benefits

  - $100,000 in cash surrender or withdrawal values

* Health Insurance

  - $300,000 in health benefit plan benefits

  - $300,000 in disability insurance benefits

  - $300,000 in disability income insurance

  - $300,000 in long-term care insurance benefits

  - $100,000 in other types of health insurance benefits

* Annuities

  - $250,000 in present value of benefits including net withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer or health maintenance organization does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Wyoming law.

EXCLUSIONS FROM COVERAGE

Policy owners, contract owners, policy holders, certificate holders and enrollees are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer or health maintenance organization was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer or health maintenance organization was not authorized to do business in this state;
- their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a stipulated premium insurance company, a local mutual burial association, a mutual assessment

company or similar plan in which the policy-holder is subject to future assessments, by an insurance exchange, or by an entity similar to those listed here.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or health maintenance organization or for which the individual has assumed the risk, such as a variable contract sold by prospectus, claims based on side letters or other documents, or misrepresentations of or regarding policy benefits;
- any policy of reinsurance (unless an assumption certificate was issued pursuant to the reinsurance policy or contract);
- interest rate yields that exceed an average rate or interest earned on an equity indexed policy;
- dividends;
- experience rating credits given in connection with the administration of a policy to a group contract holder;
- annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;
- unallocated annuity contracts (which give rights to group contract holders, not individuals);
- any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
- an obligation that does not arise under the express written terms of the policy or contract;
- any policy providing benefits under Medicare Part C, Medicare Part D, or Medicaid;
- rights to receive payments acquired through a structured settlement factoring transaction.

To learn more about the above protections, protections relating to group contracts or retirement plans, and all exclusions from coverage, please visit the Association's website at www.wylifega.org or contact:

Wyoming Life and Health
Insurance Guaranty Association
6700 N. Linder Rd, Suite 156, Box 139
Meridian, ID 83646

Toll Free: (800) 362-0944
Fax: (208) 968-0206
Website: www.wylifega.org
Email: administrator@wylifega.org

Wyoming Department of Insurance
106 East 6th Avenue
Cheyenne, WY 82002

Phone: (307) 777-7401
Toll Free: (800) 438-5768
Fax: (307) 777-2446
Website: doi.wyo.gov
Email: wyinsdep@wyo.gov

Insurance companies and agents are not allowed by Wyoming law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Wyoming law, then Wyoming law will control.

MetLife

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, or group insurance or annuity contract. In this notice, "you" refers to these individuals.

Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a bank, a legal plans company, and securities broker-dealers. In the future, we may also have affiliates in other businesses.

How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- process claims and other transactions
- perform business research
- confirm or correct your information
- market new products to you
- help us run our business
- comply with applicable laws

Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits

- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. If you have dental, long-term care, or medical insurance from us, the Health Insurance Portability and Accountability Act ("HIPAA") may further limit how we may use and share your information.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you anything we learned as part of a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

Questions

We want you to understand how we protect your privacy. If you have any questions about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

Metropolitan Life Insurance Company
General American Life Insurance Company
SafeHealth Life Insurance Company
MetLife Insurance Company of Connecticut
SafeGuard Health Plans, Inc.

MetLife

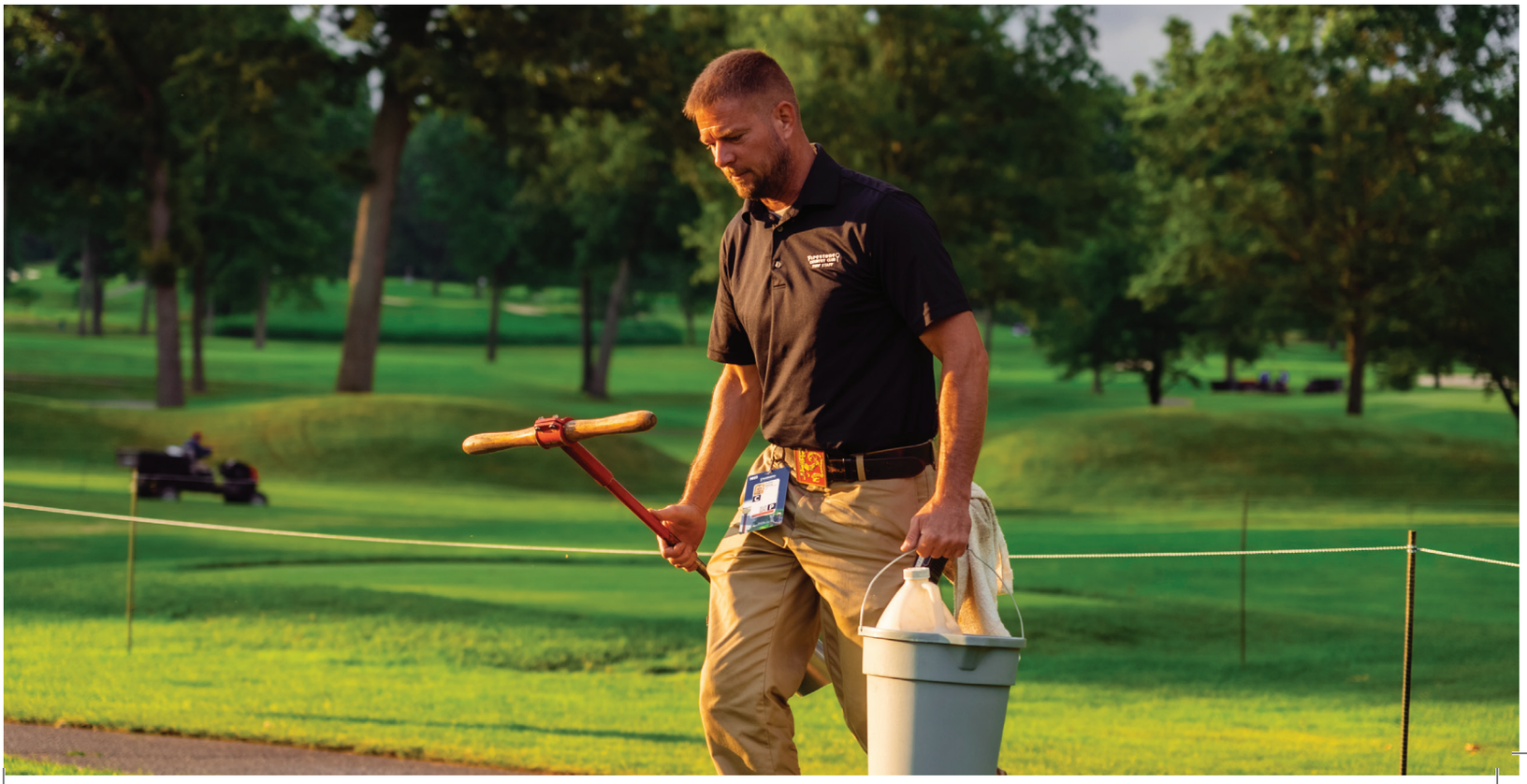
Voluntary Hospital Indemnity – MetLife Plan

Hospital Indemnity insurance pays you benefits when you are confined to a hospital, whether for planned or unplanned reasons, including having a baby. This benefit may supplement both health insurance and disability insurance, if a covered incident causes you to have expenses that your health insurance doesn't cover.

Benefits	Amount
Hospital Admission Benefit	$1,000 4X per calendar year
ICU Admission Benefit	$1,000 Paid in addition to Hospital Admission Benefit
Hospital Confinement	$200 15 days per calendar year
Newborn Nursery Care	$50 2 days per confinement
Inpatient Rehabilitation (For Injury or Sickness)	$100 15 days per calendar year
Health Screening Benefit	$100 **1 time per calendar year for all enrolled; pays IF you have your annual wellness visit.**

Bi-Weekly Rate	
Employee Only	$7.11
Employee and Spouse	$16.02
Employee and Child(ren)	$11.39
Employee and Family	$20.29

View the Hospital Indemnity Insurance Certificate by clicking **here**.



HOSPITAL INDEMNITY PLAN 1



METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK

CERTIFICATE OF HOSPITAL INDEMNITY INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this Certificate, subject to the provisions of this Certificate. References to coverage for Your Dependents throughout this Certificate only apply if insurance is in effect for Your Dependents. Please refer to the Covered Persons Specifications page and Eligibility Provisions: Dependent Insurance section for details.

This Certificate is issued to You under the Group Policy. This Certificate includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.** The Group Policy is a contract between MetLife and the Group Policyholder. It may be changed or ended without Your consent or notice to You.

Group Policyholder:	ClubCorp USA, Inc.
Group Policy Number:	0119217
MetLife Toll Free Number:	1-800-GETMET8

Important Notice: The insurance evidenced by this Certificate provides limited benefits. The benefit amounts shown on the Schedule are not based on any medical expenses that are incurred. You should have medical coverage in force when You enroll for this insurance.

This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with Your taxes.

30-Day Right to Examine Certificate. Please read this Certificate carefully. If You are not satisfied for any reason, You may notify Us that You are cancelling Your Certificate within 30 days from the date of delivery by calling us at 1-800-GETMET8. If You notify Us that You are cancelling within the 30 day period, this Certificate will be void from the beginning. We will refund any premium or Contribution paid within 30 days after We receive Your notice of cancellation.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Florida Residents: The benefits of the policy providing Your coverage are governed primarily by the laws of a state other than Florida.

Maryland Residents: The Group Policy providing coverage under this Certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

Have a complaint or need help?

If You have a problem with a claim or Your premium, call Your insurance company or HMO first. If You can't work out the issue, the Texas Department of Insurance may be able to help.

Even if You file a complaint with the Texas Department of Insurance, You should also file a complaint or appeal through Your insurance company or HMO. If You don't, You may lose Your right to appeal.

Metropolitan Life Insurance Company

To get information or file a complaint with Your insurance company or HMO:

Call: Corporate Consumer Relations Department at 1-800-438-6388

Toll-free: 1-800-438-6388

Email: Johnstown_Complaint_Referrals@metlife.com

Mail: Metropolitan Life Insurance Company
700 Quaker Lane, 2nd Floor
Warwick, Rhode Island 02886

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Metropolitan Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388

Teléfono gratuito: 1-800-438-6388

Correo electrónico: Johnstown_Complaint_Referrals@metlife.com

Dirección postal: Metropolitan Life Insurance Company
700 Quaker Lane, 2nd Floor
Warwick, Rhode Island 02886

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

NOTICE FOR RESIDENTS OF FLORIDA

If You were a resident of Florida on Your Certificate effective date, this notice applies to You.

The following provision is added to the When Insurance Ends section of this Certificate if that section does not include an Extension of Benefits provision. If the When Insurance Ends section includes an Extension of Benefits provision, We will only pay benefits under one provision, which will be the one that pays the most.

EXTENSION OF BENEFITS

If a Covered Person is Confined on the date Your insurance ends, and You do not continue insurance under the At Your Option: Continuation with Premium Payment provision, We will pay certain benefits for such Covered Person if the Confinement continues after Your insurance ends, in accordance with, and subject to all of the following:

- No benefits will be available under this Extension of Benefits provision if Your insurance ends due to non-payment of premium.
- The Confinement Benefit will be payable if requirements for payment of that benefit are met while the Covered Person is Confined. No other benefits will be payable.
- Benefits payable under this Extension of Benefits provision will be paid in accordance with and subject to the terms and conditions of this Certificate, except as set forth in this provision.
- Benefits under this Extension of Benefits provision will end on the earlier of:
  - the date the Covered Person is no longer Confined; or
  - the end of the number of days that Confinement Benefits are payable for the Confinement.
- If the Covered Person is again Confined at any time after discharge, no further benefits will be payable.

NOTICE FOR RESIDENTS OF MAINE

If You were a resident of Maine on Your Certificate effective date, this notice applies to You.

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as non-payment of a Contribution that is due. You may make this designation by completing a "Third Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this Certificate to obtain a Third Party Notice Request Form.

Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf, or any covered Dependent may request reinstatement of the Certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

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COVERED PERSON SPECIFICATIONS

Certificate Effective Date:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Group Policyholder:	ClubCorp USA, Inc.
Group Policy Number:	0119217
MetLife Contact Information:	1-800-GETMET8
Your Name:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Your Certificate Number:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Coverage for Your Dependents	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife

This Covered Person Specifications page is part of Your Certificate. Please keep it with Your Certificate.

SCHEDULE OF INSURANCE

IMPORTANT NOTE: Payment of the benefits listed in this Schedule is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate. PLEASE READ THE ENTIRE CERTIFICATE CAREFULLY.

The benefits listed only apply to Dependents if insurance is in effect for Your Dependents under this Certificate. Please refer to the Covered Person Specifications page and the Eligibility Provisions: Dependent Insurance section of this Certificate for details.

HOSPITAL BENEFITS	**Benefit / Limit**
Admission Benefit	$1,000 for the day of admission We will pay the Admission Benefit no more than: one time per Confinement; and 4 time per Covered Person, per calendar year
ICU Supplemental Admission Benefit	$1,000 for the day of admission
Confinement Benefit The Confinement Benefit is not payable for a day for which the Admission Benefit is payable.	$200 per day We will pay the Confinement Benefit for no more than: 15 days per Covered Person, per calendar year
Confinement Benefit for Newborn Nursery Care	$50 per day We will pay the Confinement Benefit for Newborn Nursery Care for no more than 2 days per newborn baby
ICU Supplemental Confinement Benefit	$200 per day We will pay the ICU Supplemental Confinement Benefit for no more than: 15 days per Covered Person, per calendar year
Inpatient Rehabilitation Benefit	$100 per day We will pay the Inpatient Rehabilitation Benefit for no more than: 15 days per Covered Person, per calendar year

OTHER BENEFITS	**Benefit / Limit**
Health Screening Benefit	$100 per day We will pay the Health Screening Benefit no more than 1 time per Covered Person, per calendar year

DEFINITIONS

As used in this Certificate, the terms listed below will have the meanings set forth below. Other terms may be defined where they are used. When defined terms are used in this Certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Accident means an act or event which:
- is unforeseen, unexpected and unanticipated;
- is definite as to time and place;
- is not a Sickness; and
- occurs while insurance is in effect under this Certificate.

The term Accident includes unavoidable exposure to the elements if such exposure was a direct result of an Accident.

Accidental means happening by Accident.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:
- the Group Policyholder's place of business;
- an alternate place approved by the Group Policyholder; or
- a place to which the Group Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Group Policyholder approved vacations, holidays or temporary business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Certificate means this Certificate including any riders attached to it.

Complications of Pregnancy means diseases or conditions, the diagnoses of which are distinct from pregnancy and not associated with normal pregnancy or Routine Childbirth, but are adversely affected or caused by pregnancy, such as: acute nephritis; nephrosis; cardiac decompensation; non-elective or emergency Caesarean section; ectopic pregnancy which is terminated; a spontaneous termination of pregnancy when a viable birth is not possible; puerperal infection; eclampsia; hyperemesis gravidarum and pre-eclampsia requiring Confinement; toxemia; missed abortion; or disease of the vascular, hemopoietic, nervous or endocrine systems.

The term Complications of Pregnancy does not include: false labor; occasional spotting; doctor prescribed rest during the period of pregnancy; morning sickness; multiple gestation pregnancy; elective abortion; or conditions of comparable severity associated with management of a difficult pregnancy.

Confined or Confinement means the assignment to a bed as a resident inpatient in a Hospital (including an Intensive Care Unit of a Hospital) on the advice of a Physician or confinement in an observation area within a Hospital for a period of no less than 20 continuous hours on the advice of a Physician.

Contribution means the amount You must pay towards the total premium charged by Us for insurance under this Certificate.

Covered Person means You and, if insured under the Group Policy for the insurance described in this Certificate, Your Dependents.

Dependent means Your Spouse, and/or Dependent Child. No person can be insured for Hospital Indemnity Insurance under the Group Policy as both an employee and a Dependent.

DEFINITIONS (Continued)

Dependent Child means the following:

- Your biological child, while such child is younger than the Dependent Child Age Limit;
- Your adopted child, while such child is younger than the Dependent Child Age Limit;
- Your stepchild, while such child is younger than the Dependent Child Age Limit;
- Your grandchild, while such child is younger than the Dependent Child Age Limit and who was able to be claimed by You as a dependent for Federal Income Tax purposes at the time You enrolled such grandchild; or
- a child for whom You must provide medical support under an order: issued under Texas Statutes, Chapter 154, Family Code; or enforceable by a court in the State of Texas.

The term Dependent Child does not mean an unborn or stillborn child.

A person cannot be insured for Hospital Indemnity Insurance as a Dependent Child of more than one employee under the Group Policy.

Dependent Child Age Limit means:

- the end of the calendar month in which the Dependent Child reaches age 26.

Dependent Insurance means insurance under this Certificate for Your Dependents.

DEFINITIONS (Continued)

Emergency Room means an area within a Hospital that is dedicated to the provision of emergency care. This area must:

- be staffed and equipped to handle trauma;
- be supervised and provide treatment by Physicians; and
- provide care seven days per week, 24 hours per day.

The term Emergency Room includes short stay observation units or clinical decision units within a Hospital that assess, within a period of less than 20 continuous hours, whether to discharge or admit patients.

Full-Time means Active Work on the Group Policyholder's regular work schedule for the class of employees to which You belong. The work schedule must be at least 30 hours per week.

Group Policy means the policy of insurance issued by Us to the Group Policyholder under which this Certificate is issued.

Group Policyholder means ClubCorp USA, Inc..

Hospice Facility means a facility, unit of a facility, public or private agency, or unit of a public or private agency that:

- is separate from a Hospital or is a separately designated unit within a Hospital; and
- meets federal certification requirements as a hospice, or is comparably licensed under the laws where it is located, to provide care or management of persons who are diagnosed with a Terminal Illness.

Hospital means a short-term, acute care, general facility which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine;
- has facilities for major Surgery either on its premises or through contractual arrangement with another Hospital;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts or alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

The term Hospital does not include a separate unit of a Hospital that is licensed as a hospice facility, nursing home, skilled nursing facility, assisted living facility, rehabilitation facility or an outpatient Surgery facility.

Injury means any bodily harm that results directly from an Accident.

DEFINITIONS (Continued)

Intensive Care Unit or **ICU** means a place which:
- is a specifically dedicated area of a Hospital that is restricted to patients who are critically ill or injured and who require intensive, comprehensive monitoring and care;
- is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- is under close observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis; and
- has a Physician assigned to the intensive care unit on a full-time basis.

The term Intensive Care Unit includes Hospital units with the following names: intensive care unit; coronary care unit; neonatal intensive care unit; pulmonary care unit; burn unit; or transplant unit.

Medical Restriction means a person is:
- restricted to the person's home under a Physician's care;
- receiving or applying to receive disability benefits from any source;
- an inpatient in a Hospital;
- receiving care in a hospice facility, an intermediate care facility or a long-term care facility; or
- receiving chemotherapy, radiation therapy or dialysis.

Newborn Nursery Care means routine well baby care provided to a newborn baby while Confined immediately following a Covered Person's childbirth of such baby.

Nurse means a registered professional nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) who is licensed under the laws where the services are performed.

The term Nurse does not include:
- You;
- Your Spouse or anyone to whom You are related by blood or marriage;
- anyone with whom You are residing;
- Your adopted or stepchild;
- anyone with whom You share a business interest; or
- Your employee.

DEFINITIONS (Continued)

Physician means:
- a person licensed to practice medicine and prescribe and administer drugs or to perform Surgery in the jurisdiction where such services are performed; or
- a medical practitioner who is licensed to provide a service for which a benefit is payable under this Certificate, according to the laws and regulations of the jurisdiction where such service is performed, and who is acting within the scope of such license.

The term Physician (for other than a dentist) does not include:
- You;
- Your Spouse or anyone to whom You are related by blood or marriage;
- anyone with whom You are residing;
- Your adopted or stepchild;
- anyone with whom You share a business interest; or
- Your employee.

Proof means Written evidence satisfactory to Us that a claimant has satisfied the conditions and requirements for any benefit described in this Certificate. When a claim is made for any benefit described in this Certificate, Proof must establish:
- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Except as provided in the Examinations and Autopsy provisions of this Certificate, Proof must be provided at the claimant's expense.

Rehabilitation Facility means a facility that:
- provides rehabilitation care services on an inpatient basis;
- is separate from a Hospital or is a separately designated unit within a Hospital; and
- maintains all required licenses and certifications.

Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by an Injury or Sickness to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians.

The term Rehabilitation Facility does not include:
- a nursing home;
- an extended care facility, unless the Covered Person is receiving rehabilitation care services on an inpatient basis at the extended care facility;
- a Skilled Nursing Facility, unless the Covered Person is receiving rehabilitation care services on an inpatient basis at the facility;
- a rest home or home for the aged;
- a Hospice Facility;
- an assisted living facility.

Routine Childbirth means the vaginal delivery of a child or children or the delivery of a child or children by elective Cesarean section.

Routine Pregnancy means a normal pregnancy that does not have Complications of Pregnancy.

DEFINITIONS (Continued)

Schedule means the Schedule of Benefits that appears in this Certificate, and the Covered Person Specifications page.

Sickness means:
- a physical illness, physical infirmity or physical disease;
- Complications of Pregnancy; or
- Routine Childbirth.

The term Sickness does not include Routine Pregnancy.

Signed means any method executed or adopted by a person with the present intention to authenticate a record. The signature may be transmitted by paper or electronic media, provided it is consistent with applicable law.

Skilled Nursing Facility means a facility that provides nursing care that meets all of the following requirements:
- if licensing or certification is required, maintains all appropriate licensing or certification under the laws where it is located as a skilled or intermediate nursing facility;
- has 24 hour a day care performed by an awake, and trained or certified staff supervised by a Nurse;
- is separate from a Hospital or is a separately designated unit within a Hospital;
- keeps a Written record of services performed for each client;
- has established procedures to obtain emergency medical care; and
- services are not limited to provision of food, shelter, and other residential services such as laundry.

The term Skilled Nursing Facility does not include a Hospice Facility.

Spouse means Your lawful spouse.

Surgery means a procedure performed by a Physician involving an incision of the Covered Person's skin or tissue that, in and of itself, is intended to be curative, palliative or exploratory.

United States means the United States of America, its territories and its possessions.

We, Us and **Our** mean Metropolitan Life Insurance Company.

Write, Written or **Writing** means a record that may be transmitted by paper or electronic media, and that is consistent with applicable law.

You and **Your** means an employee who is insured under the Group Policy for the insurance described in this Certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS

CLASS 1

All Active Full-Time Employees

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the Hospital Indemnity Insurance available for Your eligible class.

If You are in an eligible class on the date insurance becomes available for the class, You will be eligible for insurance on the date You complete any applicable eligibility waiting period set by the Group Policyholder.

If you enter an eligible class after the date insurance becomes available to members of that class, You will be eligible for insurance on the date You complete any applicable eligibility waiting period set by the Group Policyholder.

ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the required form. You must also provide Written permission to deduct Contributions from Your pay for such insurance, if You are required to make such Contributions.

DATE YOUR INSURANCE TAKES EFFECT

Provided that You are Actively at Work in an eligible class, insurance under this Certificate will take effect for You on the Certificate effective date. If You are not Actively at Work in an eligible class on the date insurance would otherwise take effect, insurance will take effect on the date You return to Active Work in an eligible class.

BENEFIT CHANGES

Once Your insurance takes effect, You may only change Your benefits in accordance with the options available through the Group Policyholder. Please contact Us or the Group Policyholder for more information.

If You are not Actively at Work in an eligible class on the date an increase in benefits would otherwise take effect, the increase will not take effect until You return to Active Work in a class that is eligible for the increase.

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE

ELIGIBLE CLASS FOR DEPENDENT INSURANCE

All Class 1 employees of the Group Policyholder as specified in the Eligibility Provisions: Insurance For You section of this Certificate are eligible for Dependent Insurance.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

If You are in a class of employees who are eligible for Dependent Insurance on the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date Your insurance takes effect; and
- the date an individual becomes Your first Dependent.

If You enter a class of employees who are eligible for Dependent Insurance after the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date You enter a class eligible for Dependent Insurance; and
- the date an individual becomes Your first Dependent.

ENROLLMENT PROCESS

If You become eligible for Dependent Insurance, You may enroll for such insurance by providing Us with any information We require for each Dependent to be insured. You must also provide Written permission to deduct Contributions from Your pay for Dependent Insurance, if You are required to make such Contributions.

DATE DEPENDENT INSURANCE TAKES EFFECT

Newborn Children

A Dependent Child born to You while insurance is in effect under the Certificate will be covered:

- from the moment of birth and does not need to be enrolled if Dependent Insurance is already in effect for at least one other Dependent Child; or
- for 31 days from the moment of birth if Dependent Insurance is not already in effect for at least one other Dependent Child. To continue coverage beyond the first 31 days You must notify Us of the child's birth and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the newborn child.

The effective date of insurance for a newborn child will be determined without regard to whether the child is under a Medical Restriction.

Adopted Children

A Dependent Child adopted by You or Placed for Adoption with You while insurance is in effect under the Certificate will be covered:

- from the moment of birth if Placement for Adoption or adoption occurs within 31 days after the child's birth; or
- from the date of adoption or Placement for Adoption if the child is adopted by You or Placed for Adoption with You more than 31 days after the child's birth.

The child does not need to be enrolled if Dependent Coverage is already in effect for at least one other Dependent Child. If Dependent Coverage is not already in effect for at least one other Dependent Child, then to continue the child's coverage beyond the first 31 days of coverage, You must notify Us of the child's adoption or Placement for Adoption and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the adopted child. You must do this within 31 days of the date the child is adopted by You or Placed for Adoption with You.

The effective date of insurance for a newly adopted child will be determined without regard to whether the child is under a Medical Restriction.

Placed for Adoption or **Placement for Adoption** means:
- the assumption and retention by You of a legal obligation for total or partial support of a child in anticipation of Your adoption of the child; or
- that there is a suit to which You are a party, in which You seek to adopt the child.

A Child Covered Pursuant to a Medical Support Order

A child for whom You are required to provide insurance pursuant to a medical support order issued under Texas Statutes Chapter 154, Family Code; or enforceable by a court in the State of Texas, that is entered while insurance is in effect under the Certificate will be covered from the date specified in the order.

The child does not need to be enrolled if Dependent Coverage is already in effect for at least one other Dependent Child. If Dependent Coverage is not already in effect for at least one other Dependent Child, then to continue the child's coverage beyond the first 31 days of coverage, You must notify Us of Your obligation to cover the child and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the child. You must do this within 31 days of the date You become obligated to cover the child.

The effective date of insurance for a child who becomes covered under this Certificate pursuant to a medical support order while this insurance is in effect under the Certificate will be determined without regard to whether the child is under a Medical Restriction.

Other Dependents

Dependent Insurance for a Dependent who is not under a Medical Restriction will take effect on the later of:
- the date You are enrolled for Dependent Insurance for such Dependent; or
- the date a person becomes Your Dependent.

If a Dependent is under a Medical Restriction on the date insurance for such Dependent would otherwise take effect, insurance for the Dependent will take effect on the date the Dependent is no longer under a Medical Restriction.

BENEFIT CHANGES

Benefit changes with respect to a Dependent are subject to the Benefit Changes provision in the Eligibility Provisions: Insurance for You section of this Certificate.

HOSPITAL BENEFITS

Payment of the Hospital Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

HOSPITAL ADMISSION BENEFITS

Admission Benefit

If a Covered Person is admitted for Confinement to a Hospital for treatment of an Injury or Sickness, We will pay the Admission Benefit shown on the Schedule for the day of admission, subject to all of the following:

- The admission must occur on or after the date that coverage took effect under this Certificate for such Covered Person.
- The Admission Benefit is not payable for Emergency Room treatment or outpatient treatment.
- We will only pay the Admission Benefit for a Covered Person for one Hospital admission at a time, even if the admission is caused by more than one Injury or Sickness or a combination of Injury and Sickness.
- For Hospital admission for treatment of an Injury, the admission must occur within 180 days after the Accident occurs.
- If a Covered Person is discharged from a Confinement for which We paid an Admission Benefit and, within 90 days is again Confined for the same or related Injury or Sickness, We will treat the subsequent Confinement as a continuation of the previous Confinement (and an additional Admission Benefit will not be payable).
- We will only pay an Admission Benefit for a newborn baby who is born in a Hospital if, due to a Sickness or Injury, the newborn baby is admitted to the Intensive Care Unit.
- If a Covered Person is admitted to a Hospital and is then transferred to another Hospital, We will not pay an additional Admission Benefit.
- We will pay the Admission Benefit no more than the number of times shown on the Schedule.

ICU Supplemental Admission Benefit

We will pay the ICU Supplemental Admission Benefit shown on the Schedule, in addition to the Admission Benefit, if a Covered Person, upon initial admission for Confinement to a Hospital for treatment of an Injury or Sickness, is admitted to an ICU, subject to all of the following:

- The admission must meet the requirements for payment of the Admission Benefit.
- For an ICU admission for treatment of an Injury, the admission must occur within 180 days after the Accident occurs.
- If the Covered Person moves to an ICU after initial admission to a Hospital, We will not pay the ICU Supplemental Admission Benefit.

HOSPITAL CONFINEMENT BENEFITS

Confinement Benefit

If a Covered Person is Confined in a Hospital for treatment of an Injury or Sickness, We will pay the Confinement Benefit shown on the Schedule for each day of Confinement, subject to all of the following:

- The Confinement must begin while coverage is in effect under this Certificate for such Covered Person. For Confinement for treatment of an Injury, the Confinement must begin within 180 days after the Accident occurs.
- If a Covered Person is Confined in a Hospital and is then transferred to another Hospital, We will treat the transfer as a continuation of the prior Confinement.
- We will only pay one Confinement Benefit per Covered Person, per day.
- We will not pay a Confinement Benefit for a day that the Admission Benefit is payable.
- We will pay the Confinement Benefit for no more than the number of days shown on the Schedule.
- For a newborn baby who is receiving Newborn Nursery Care and is not Confined for treatment of a physical illness, infirmity, disease or Injury, We will pay the Confinement Benefit for Newborn Nursery Care shown on the Schedule for such baby, while Confined, up to the number of days shown on the Schedule. If a newborn baby is Confined for treatment of a physical illness, infirmity, disease or Injury, We will pay the Confinement Benefit instead of the Confinement Benefit for Newborn Nursery Care.

ICU Supplemental Confinement Benefit

We will pay the ICU Supplemental Confinement Benefit shown on the Schedule, in addition to the Confinement Benefit, for each day a Covered Person is Confined in an ICU for treatment of an Injury or Sickness, subject to all of the following:

- The ICU Confinement must meet the requirements for payment of the Confinement Benefit.
- We will only pay the ICU Supplemental Confinement Benefit for a day on which the Confinement Benefit is payable.
- For an ICU Confinement for treatment of an Injury, Confinement in the Intensive Care Unit must begin within 180 days after the Accident occurs.
- We will pay the ICU Supplemental Confinement Benefit for no more than the number of days shown on the Schedule.

INPATIENT REHABILITATION BENEFIT

If a Covered Person is transferred to a Rehabilitation Facility, as a resident inpatient, immediately after a period of Confinement for treatment of an Injury or Sickness for which We paid an Admission Benefit or Confinement Benefit, We will pay the Inpatient Rehabilitation Benefit shown on the Schedule for the period of the continuous stay, subject to all of the following:

- For treatment of an Injury, the Covered Person’s inpatient stay in the Rehabilitation Facility must start within 365 days after the Accident occurs.
- If the Covered Person is discharged from the Rehabilitation Facility and, within 14 days is again admitted to a Rehabilitation Facility as a resident inpatient for treatment of the same or related Injury or Sickness, We will treat the subsequent Rehabilitation Facility stay as a continuation of the previous stay.
- We will not pay the Inpatient Rehabilitation Benefit for any day for which We paid an Admission Benefit or a Confinement Benefit.
- We will only pay one Inpatient Rehabilitation Benefit per Covered Person, per day.
- We will pay the Inpatient Rehabilitation Benefit for no more than the number of days shown on the Schedule.

OTHER BENEFITS

Payment of the Other Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

HEALTH SCREENING BENEFIT

If a Covered Person takes one of the screening/prevention measures listed below while insured under this Certificate, upon submission of Proof, We will pay the Health Screening Benefit shown on the Schedule for the day that the measure is taken, subject to all of the following:

- We will not pay a Health Screening Benefit for a screening/prevention measure if benefits are paid or payable for that same screening/prevention measure under another section of this Certificate.
- We will pay the Health Screening Benefit no more than the number of times shown on the Schedule.

The screening/prevention measures for which a Health Screening Benefit may be paid are:

- routine health check-up exam
- biopsies for cancer
- blood chemistry panel
- blood test to determine total cholesterol
- blood test to determine triglycerides
- bone marrow testing
- breast MRI
- breast ultrasound
- breast sonogram
- cancer antigen 15-3 blood test for breast cancer (CA 15-3)
- cancer antigen 125 blood test for ovarian cancer (CA 125)
- carcinoembryonic antigen blood test for colon cancer (CEA)
- carotid doppler
- chest x-rays
- clinical testicular exam
- colonoscopy
- complete blood count (CBC)
- dental exam
- digital rectal exam (DRE)
- Doppler screening for cancer
- Doppler screening for peripheral vascular disease
- echocardiogram
- electrocardiogram (EKG)
- electroencephalogram (EEG)
- endoscopy
- eye exam
- fasting blood glucose test
- fasting plasma glucose test
- flexible sigmoidoscopy
- hearing test
- hemoccult stool specimen
- hemoglobin A1C
- human papillomavirus (HPV) vaccination
- immunization
- lipid panel
- mammogram
- oral cancer screening

OTHER BENEFITS (Continued)

- pap smears or thin prep pap test
- prostate-specific antigen (PSA) test
- serum cholesterol test to determine LDL and HDL levels
- serum protein electrophoresis
- skin cancer biopsy
- skin cancer screening
- skin exam
- stress test on bicycle or treadmill
- successful completion of smoking cessation program
- tests for sexually transmitted infections (STIs)
- thermography
- two hour post-load plasma glucose test
- ultrasounds for cancer detection
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
- virtual colonoscopy
- coronavirus testing

EXCLUSIONS

We will not pay benefits for any loss due to an Accident or Sickness for a Covered Person caused or contributed to by:

- war, whether declared or undeclared; or act of war;
- the Covered Person's active participation in an insurrection, rebellion, riot, or terrorist act;
- the Covered Person's engagement in any activity that constitutes a felony under the laws of the jurisdiction in which the activity occurred;
- dental procedures or Surgery except as the result of an Accident causing Injury to a sound natural tooth;
- cosmetic Surgery, except when such Surgery is performed to:
  - treat an Injury or Sickness;
  - correct a disorder of normal bodily function or structure that was caused by an Injury or Sickness for which coverage is not otherwise excluded under this Certificate; or
  - reconstruct a part of the body which was disfigured or removed as a result of an Injury or Sickness for which coverage is not otherwise excluded under this Certificate; or
- activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority.

In addition, We will not pay benefits for:

- a Covered Person while incarcerated in any type of penal or detention facility; or
- any of the following outside of the United States, Canada or Mexico:
  - any medical or healthcare treatment, services or transportation; or
  - any inpatient admission or stay in any medical or health care facility.

The following additional exclusions apply to payment of benefits for any loss due to an Accident:
We will not pay benefits for any loss due to an Accident for a Covered Person caused or contributed to by:

- the Covered Person's operation, while intoxicated, of a motor vehicle involved in the incident. For purposes of this exclusion:
  - intoxicated means that the Covered Person's blood alcohol level met or exceeded .08%; and
  - motor vehicle means any vehicle that is powered by a motor, including, but not limited to: an automobile; a boat; a motorcycle; a truck; an all-terrain vehicle; or a snow mobile;
- the Covered Person's travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight;
- the Covered Person parachuting or otherwise exiting from a motorized or non-motorized aircraft while such aircraft is in flight, except for self-preservation;
- the Covered Person riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- the Covered Person participating in any semi-professional or professional competitive athletic activity for which any type of compensation or remuneration is received; or
- the Covered Person bungee jumping, base jumping, hang gliding, para-kiting, sail-gliding, scuba diving deeper than 130 feet; spelunking; or mountaineering including rock climbing using ropes and any other climbing equipment. For the purposes of this exclusion the term mountaineering does not include backpacking, mountain biking, hiking or trail running.

EXCLUSIONS (Continued)

The following additional exclusions applies to payment of benefits for any loss due to a Sickness:

- We will not pay benefits under this Certificate for a Dependent Child's Routine Childbirth and any well baby or nursing care provided to the Dependent Child's newborn child.

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WHEN INSURANCE ENDS

Please Note: If insurance ends under this section, in certain cases it may be continued as stated in the Continuation of Insurance section of this Certificate. Please see that section for details.

DATE YOUR INSURANCE ENDS

Your insurance under this Certificate will end on the earliest of:

- the date the Group Policy ends;
- the date You die;
- the date insurance ends for Your class;
- the end of the period for which the last full premium has been paid for Your insurance;
- the end of the calendar month in which You notify Us that You wish to cancel Your insurance;
- the end of the calendar month in which You cease to be in an eligible class, subject to the Change in Class provision of the Eligibility Provisions: Insurance for You section; or
- the end of the calendar month in which Your employment ends.

For residents of Massachusetts:

If You are a resident of Massachusetts and Your insurance under this Certificate is ending under the above provision because Your employment has ended, instead of insurance ending on the date Your employment ends, the following timelines apply:

- If Your employment ends for any reason other than a Plant Closing or a Partial Plant Closing, Your insurance will end 31 days after the date Your employment ends. However, if during such 31 day period You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate, insurance under this Certificate will end on the date You become entitled to such other benefits.

- If Your employment ends due to a Plant Closing or a Partial Plant Closing Your insurance will end 90 days after the date Your employment ends. However, if during such 90 day period, You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate insurance under this Certificate will end on the date You become entitled to such other benefits.

DATE DEPENDENT INSURANCE ENDS

A Dependent's insurance under this Certificate will end on the earliest of:

- the date Your insurance under this Certificate ends;
- the date Dependent Insurance ends under the Group Policy for all employees or for Your class;
- the end of the calendar month in which the person ceases to be a Dependent;
- the end of the calendar month in which You cease to be in a class that is eligible for Dependent Insurance;
- the end of the calendar month in which the Dependent is no longer eligible as described in the Eligible Classes for Dependent Insurance provision; or
- the end of the period for which the last full premium has been paid for insurance for the Dependent.

WHEN INSURANCE ENDS (Continued)

CHANGE IN CLASS

If there is more than one class eligible for insurance under the Group Policy, and each class has its own certificate, instead of receiving a new certificate when You move between classes, You will remain insured under this Certificate if:

- You move to a class that is eligible for Hospital Indemnity Insurance under the Group Policy; and
- the benefits available to Your new class are identical to the benefits available under this Certificate.

In all other cases when You move between classes, Your insurance under this Certificate will end on the date You are no longer a member of the class eligible for insurance under this Certificate.

CONTINUATION OF INSURANCE

AT YOUR OPTION: CONTINUATION WITH PREMIUM PAYMENT

If Your insurance ends under the Date Your Insurance Ends provision of this Certificate, in certain situations, it may be continued for You and Your Dependents, as described in this provision. This is referred to in this provision as "Continued Insurance". Evidence of insurability will not be required to obtain Continued Insurance. For purposes of this provision, insurance in effect under the Group Policy for which the Group Policyholder remits premium is referred to in this provision as "Group Billed Insurance".

Except as described below, Continued Insurance is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

Requirements for Continued Insurance

Continued Insurance will be available to You if:

- Your Group Billed Insurance ends for any reason other than:
  - non-payment of premium or Contribution; or
  - the end of the Group Policy, provided that Continued Insurance will be available to You if You do not become eligible, within 30 days after the end of the Group Policy, for hospital indemnity insurance under another policy of group insurance available through the Group Policyholder;
- We receive Your completed Written request for Continued Insurance on a form approved by Us within 31 calendar days after Your Group Billed Insurance ends; and
- You pay premiums required for Continued Insurance by the due date specified in the premium notice sent to You.

Changes in Continued Insurance

You may elect to decrease Your insurance after the date that Continued Insurance goes into effect for You if a lower benefit option is available. In addition, You may end insurance for any or all of Your Dependents. Please contact Us for information. You may not increase insurance once Continued Insurance goes into effect.

Contributions for Continued Insurance

The Contribution that You must pay for Continued Insurance is the amount of Your Contribution for Your Group Billed Insurance before it ended, plus any amount of premium that the Group Policyholder paid. The Contribution that You must pay for Continued Insurance will be determined on the same basis as premium rates charged for Group Billed Insurance. We have the right to change premium rates in accordance with the terms set forth in the Group Policy. All payments for Continued Insurance must be made directly to Us by the due date specified in the premium notice We send to You.

CONTINUATION OF INSURANCE (Continued)

End of Continued Insurance

Continued Insurance will end on the earliest of the following dates:

- the date You die;
- if You do not pay a Contribution that is required for Continued Insurance, the end of the period for which the last full premium has been paid for Your insurance;
- with respect to Continued Insurance for a Dependent:
  - the date Continued Insurance for You ends for any reason;
  - the end of the calendar month in which the Dependent no longer meets the definition of a Dependent; or
  - the end of the calendar month in which the Dependent is no longer eligible as described in the Eligibility Provisions: Dependent Insurance section of this Certificate.

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if that child is incapable of self-sustaining employment and is chiefly dependent on You for support and maintenance because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Dependent Child attains the age limit and at reasonable intervals after such date, but no more often than annually after the two year period following such Dependent Child's attainment of the limiting age.

Except as stated in the Date Dependent Insurance Ends provision of the When Insurance Ends section of this Certificate, insurance will continue while such Dependent Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap;
- remains chiefly dependent on You for support and maintenance; and
- continues to qualify as a Dependent Child, except for the age limit.

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify under the Family and Medical Leave Act of 1993 (FMLA) or similar state laws for continuation of insurance. Please contact the Group Policyholder for information regarding the FMLA or any similar state law.

CLAIMS

NOTICE OF CLAIM

You must give Us notice of a claim under this Certificate by Writing to Us or calling Us at the toll free number shown on the face page of this Certificate within 30 days of the date of the loss.

CLAIM FORM

When We receive notice of a claim under this Certificate, We will provide You or the claimant with a claim form. If We do not provide the claim form before the 16th day from the date We received notice of claim, Our claim form requirements will be satisfied if We are provided with the required Proof in support of the claim.

PROOF OF LOSS

Proof must be provided to Us not later than 90 days after the date of the loss. If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible, but in no event, other than in the absence of the legal capacity of the claimant, later than15 months from the date Proof of the loss is required. When We receive the claim form and Proof, We will review the claim and, provide notification in Writing of Our approval or denial of the claim no later than the 15th business day after the date We receive documentation in support of the claim.

PAYMENT OF BENEFITS

If We approve a claim, We will pay benefits no later than 60 days after the date We receive Proof, subject to the terms and provisions of this Certificate and the Group Policy. If We deny the claim, Our notice will state the reason(s) for the denial. If We cannot approve or deny the claim within 15 business days after We receive documentation in support of the claim, We will provide notification within 15 business days, stating that We need additional time to review the claim and the reason(s) why. We will notify You or the claimant of Our decision to approve or deny the claim within 45 days after the date that We provide notification that We that We need additional time to review the claim.

Unless You have assigned this insurance, all benefits to be paid under this Certificate will be paid to You, except as follows:

- If You are not alive to receive benefits that are payable to You, We will pay any benefits in accordance with the provision below titled Your Beneficiary.
- If You are living when benefits are to be paid to You, but You are not legally competent to claim or receive the benefits, We may pay up to $10,000 to anyone related to You by blood or marriage who We believe is entitled to payment of the benefits. If We make such a payment in good faith, We will not be liable to anyone for the amount We pay. Any remaining benefits will be paid to Your legal representative.

If benefits have been assigned, We will pay benefits in accordance with the Assignment provision of the General Provisions section.

YOUR BENEFICIARY

A beneficiary may be named by You to receive any benefit that becomes payable to You under this Certificate that You are not alive to receive.

You may request to change Your beneficiary at any time. A beneficiary change request must be made to Us in Writing. Once the request is recorded, the change will take effect as of the date You sign the request, whether or not You are living when We receive the request. The change will be subject to any legal restrictions. It will also be subject to any payment We made or action We took before We recorded the change. If You designated two or more beneficiaries and their shares are not specified, they will share the benefit payable equally.

If there is no beneficiary designated or no surviving beneficiary at Your death, We will determine the beneficiary according to the following order:

1. Your Spouse, if alive;
2. Your child(ren), if there is no surviving Spouse;
3. Your parent(s), if there is no surviving child;
4. Your sibling(s), if there is no surviving parent; or
5. Your estate, if there is no surviving sibling.

Instead of making payment in the order above, We may pay Your estate. Any payment made in good faith will discharge our liability to the extent of such payment. If a beneficiary or a Payee is a minor or incompetent to receive payment, We will pay that person's guardian.

AUTHORIZATIONS

We may require that You provide authorization for Us to obtain medical information and any other information pertinent to Your claim.

EXAMINATIONS

During the pendency of a claim, at Our expense and as often as is reasonably necessary, We may require a Covered Person to have an independent examination by a Physician of Our choice.

During the pendency of a claim, at Our expense and as often as is reasonably necessary, We may have Our representatives conduct telephone or in-person interviews with You regarding Your claim.

AUTOPSY

At Our expense, We have the right to make a reasonable request for an autopsy and/or exhumation where permitted by law. Any such request will set forth the reasons We are requesting the autopsy or exhumation.

TIME LIMIT ON LEGAL ACTIONS

A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends three years after the date such Proof is required to be filed.

REFUND TO US FOR OVERPAYMENT OF BENEFITS

If, at any time, We determine that the benefits paid under this Certificate were more than the benefits due:

- You, or any other person, entity or health care provider to whom We over paid benefits have the obligation to reimburse Us for the amount of such overpayment; and
- We have the right to recover the amount of such overpayment from You, or any other person, entity or health care provider to whom We over paid benefits, including offsetting future benefits payable to You or such other person, entity or health care provider by an amount equivalent to the overpayment.

GENERAL PROVISIONS

ENTIRE CONTRACT

Your insurance is provided under a contract of group insurance with the Group Policyholder. The entire contract with the Group Policyholder is made up of the following:

- the Group Policy and its Exhibits, which include the Certificate(s);
- the Group Policyholder's application; and
- any amendments and/or endorsements to the Group Policy.

INCONTESTABILITY: STATEMENTS MADE BY YOU

Any statement made by You will be considered a representation and not a warranty. We will not use such a statement to void insurance, reduce benefits or defend a claim unless the following requirements are met:

- the statement is in a form that is in Writing;
- You have Signed the form; and
- a copy of the form has been given to You or Your beneficiary.

We will not use Your statements which relate to insurability to contest this insurance after it has been in force for 2 years, unless the statement is fraudulent. In addition, We will not use such statements to contest a benefit increase after the benefit increase has been in force for 2 years, unless such statement is fraudulent.

MISSTATEMENTS

If Your or Your Dependent's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or Contributions.

ASSIGNMENT

The benefits under the Group Policy are not assignable prior to a claim for benefits, except to a Physician or other health care provider who provides health care services to You, or except as required by law.

CONFORMITY WITH LAW

If the terms and provision of this Certificate do not conform to any applicable law, this Certificate shall be interpreted to so conform.

STANDARD OF TIME

All insurance becomes effective and terminates at 12:01 A.M. Eastern Standard Time, or at 12:01 A.M. Eastern Daylight Time if Daylight Savings Time is then being observed.

YOUR BENEFIT PLAN

ClubCorp USA, Inc.

All Full-Time Hourly and Salary Employees and Variable Hour Employees Who Qualify As Full-Time Employees For Purposes Of Insurance

Basic Life Insurance

Supplemental Life Insurance

Dependent Life Insurance

Accidental Death and Dismemberment Insurance

Certificate Date: January 1, 2021

ClubCorp USA, Inc.
3030 LBJ Freeway Suite 600
Dallas, TX 75234

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

ClubCorp USA, Inc.



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE RIDER

Group Policy No.:	119217-1-G
Policyholder:	ClubCorp USA, Inc.
Effective Date:	January 1, 2021

The Certificate is changed as shown below:

The Certificate is revised to add the following:

"**How We Will Pay Benefits**

Unless the Beneficiary requests payment by check, when the Certificate states that We will pay benefits in "one sum", "lump sum" or a "single sum", We may pay the full benefit amount:

1. by check;
2. by establishing an account that earns interest and provides the Beneficiary with immediate access to the full benefit amount; or
3. by any other method that provides the Beneficiary with immediate access to the full benefit amount.

Other modes of payment may be available upon request. For details, call Our toll free number shown on the Certificate Face Page."

This rider is to be attached to and made a part of the Certificate



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

Policyholder:	ClubCorp USA, Inc.
Group Policy Number:	119217-1-G
Type of Insurance:	Term Life & Accidental Death and Dismemberment Insurance
MetLife Toll Free Number(s): For Claim Information	FOR LIFE CLAIMS: 1-800-638-6420

PLEASE AFFIX THE STICKER SHOWING THE EMPLOYEE'S NAME AND EFFECTIVE DATE IN THIS SPACE.

THIS CERTIFICATE ONLY DESCRIBES TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE.

FOR CALIFORNIA RESIDENTS: REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON YOUR EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.

PAYMENT OF ACCELERATED BENEFITS WILL REDUCE THE AMOUNT OF YOUR LIFE INSURANCE THAT WILL BE PAID UPON YOUR DEATH.

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

NOTICE FOR RESIDENTS OF TEXAS

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Metropolitan Life Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Corporate Consumer Relations Department at 1-800-638-6420

Toll-free: 1-800-638-6420

Email: Johnstown_Complaint_Referrals@metlife.com

Mail: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Metropolitan Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-638-6420

Teléfono gratuito: 1-800-638-6420

Correo electrónico: Johnstown_Complaint_Referrals@metlife.com

Dirección postal: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

NOTICE FOR RESIDENTS OF WASHINGTON

LIFE INSURANCE: ACCELERATED BENEFIT OPTION (ABO)

The Life Insurance accelerated benefit does not and is not intended to qualify as long-term care under Washington state law. Washington state law prevents this accelerated life benefit from being marketed or sold as long-term care.

NOTICE FOR RESIDENTS OF ALL STATES

LIFE INSURANCE BENEFITS WILL BE REDUCED IF AN ACCELERATED BENEFIT IS PAID

DISCLOSURE: The Life Insurance accelerated benefit offered under this certificate is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If this benefit qualifies for such favorable tax treatment, the benefit will be excludable from Your income and not subject to federal taxation. Tax laws relating to accelerated benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which You could receive an accelerated benefit excludable from income under federal law.

DISCLOSURE: Receipt of an accelerated benefit may affect Your, Your Spouse's or Your family's eligibility for public assistance programs such as Medical Assistance (Medicaid), Aid to Families with Dependent Children (AFDC), Supplementary Social Security Income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect Your, Your Spouse's and Your family's eligibility for public assistance.

NOTICE FOR RESIDENTS OF ARKANSAS

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
Consumer Services Division
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR METLIFE AT:

METROPOLITAN LIFE INSURANCE COMPANY
ATTN: CONSUMER RELATIONS DEPARTMENT
500 SCHOOLHOUSE ROAD
JOHNSTOWN, PA 15904

1-800-638-6420

IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA DEPARTMENT OF INSURANCE DEPARTMENT AT:

DEPARTMENT OF INSURANCE
CONSUMER SERVICES
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013

WEBSITE: http://www.insurance.ca.gov/

1-800-927-4357 (within California)
1-213-897-8921 (outside California)

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

NOTICE FOR RESIDENTS OF IDAHO

If You have a question concerning Your coverage or a claim, first contact the Policyholder. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife, You may write to:

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company

1-800-638-6420

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance

Consumer Services Division

311 West Washington Street, Suite 300

Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at www.in.gov/idoi

NOTICE FOR RESIDENTS OF MAINE

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as for nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this certificate to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, You or any person authorized to act on Your behalf may request reinstatement of the certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

NOTICE FOR MASSACHUSETTS RESIDENTS

CONTINUATION OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

1. If Your AD&D Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.

2. If Your AD&D Insurance ends because:

    - You cease to be in an Eligible Class; or
    - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your AD&D Insurance under the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

NOTICE FOR RESIDENTS OF MINNESOTA

This is a life insurance policy which pays accelerated death benefits at your option under conditions specified in the policy. This policy is not a long-term care policy meeting the requirements of sections M.S.62A.46 to 62A.56 or chapter 62S.

NOTICE FOR RESIDENTS OF MINNESOTA
CONTINUATION OF BASIC LIFE INSURANCE WITH PREMIUM PAYMENT

If Your Life Insurance ends due to termination of Your employment for any reason other than gross misconduct, You may continue such insurance for You.

If You are eligible for continuation of Life insurance, Your employer will notify You of:

- Your right to elect to continue Life Insurance for You;
- the amount You must pay each month to Your employer to keep such insurance in force;
- instructions for payment; and
- the time that payments are due.

The amount of the premium You will be required to pay for continuation of Life Insurance will not exceed 102 percent of the amount of premium required to be paid for active employees in Your class for such insurance (this includes any premium amounts paid by the employer as well as the employee).

You will have 60 days within which to elect to continue Life Insurance under this section. The 60 day period begins to run on the date Life Insurance would otherwise end or on the date upon which notice of the right to continue Life Insurance is received, whichever is later. If You die during the 60 day election period, we will consider You to have elected to continue Life Insurance under this section.

If Your employer fails to notify You of Your right to continue insurance under this section, or fails to forward a required premium to Us that You have paid, causing insurance for You to end, then Your employer will become liable for these benefits to the same extent as, and in place of, us.

If You continue Life Insurance under this section, any reductions in Life Insurance that would have applied if You were Actively at Work apply to the continued insurance.

Continuation of Life Insurance under this section will end on the earliest of:

- the date the group policy ends for all employees or for the class of employees to which you belonged when Your Active Work ceased;
- the date you fail to make a required premium payment when due;
- the date you become covered for life insurance under this or any other group term life insurance plan; or
- the end of 18 months following the date Your Active Work ended.

When a continuation under this section ends, You may buy an individual policy of life insurance from Us. The details of this option are described in the section LIFE INSURANCE: CONVERSION OPTION FOR YOU entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU. For the purpose of that section, the end of this continuation will be considered the end of your employment.

Effect of Previous Conversion

If You converted Life Insurance to an individual policy, We will only pay Life Insurance under this section if such individual policy is returned to Us. If it is returned to Us, We will refund to Your estate the premiums paid for such policy without interest, less any debt incurred under such policy.

If such individual policy is not returned to Us, We will pay the life insurance in effect under the individual policy.

We will not pay insurance under both the Group Policy and the individual policy.

NOTICE FOR RESIDENTS OF MISSOURI

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

EXCLUSIONS

If You reside in Missouri the exclusion for "suicide or attempted suicide" is as follows:

"suicide or attempted suicide while sane"

LIFE INSURANCE

GENERAL PROVISIONS

If You reside in Missouri the suicide provision is as follows:

Suicide

If You commit suicide within 1 year from the date Life Insurance for You takes effect, We will not pay such insurance and Our liability will be limited as follows:

- any premium paid by You will be returned to the Beneficiary.
- any premium paid by the Policyholder will be returned to the Policyholder.

If You commit suicide within 1 year from the date an increase in Your Life Insurance takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

If a Dependent commits suicide within 1 year from the date Life Insurance for such Dependent takes effect, We will not pay such insurance and Our liability will be limited as follows:

- any premium paid by You will be returned to the Beneficiary.
- any premium paid by the Policyholder will be returned to the Policyholder.

If a Dependent commits suicide within 1 year from the date an increase in Life Insurance for such Dependent takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

NOTICE FOR RESIDENTS OF NORTH DAKOTA

GENERAL PROVISIONS

If You reside in North Dakota the suicide provision is as follows:

Suicide

If You commit suicide within 1 year from the date Life Insurance for You takes effect, We will not pay such insurance and Our liability will be limited as follows:

- any premium paid by You will be returned to the Beneficiary.
- any premium paid by the Policyholder will be returned to the Policyholder.

If You commit suicide within 1 year from the date an increase in Your Life Insurance takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

If a Dependent commits suicide within 1 year from the date Life Insurance for such Dependent takes effect, We will not pay such insurance and Our liability will be limited as follows:

- any premium paid by You will be returned to the Beneficiary.
- any premium paid by the Policyholder will be returned to the Policyholder.

If a Dependent commits suicide within 1 year from the date an increase in Life Insurance for such Dependent takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

NOTICE FOR RESIDENTS OF ALL STATES

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

NOTICE FOR RESIDENTS OF UTAH

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 in disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

NOTICE FOR RESIDENTS OF THE STATE OF VERMONT

Vermont law provides that the following apply to Your certificate:

Domestic Partner means each of two people, one of whom is an Employee of the Policyholder, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "**Spouse**" appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

NOTICE FOR RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife
200 Park Avenue
New York, New York 10166
Attn: Corporate Consumer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:
1-800-638-6420

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance
Life and Health Division
P.O. Box 1157
Richmond, VA 23218-1157
1-804-371-9691 - phone
1-877-310-6560 - toll-free
1-804-371-9944 - fax
www.scc.virginia.gov - web address
BureauOfInsurance@scc.virginia.gov - email

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

NOTICE FOR RESIDENTS OF THE STATE OF WASHINGTON

Washington law provides that the following apply to Your certificate:

Wherever the term "**Spouse"** appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Domestic Partner means each of two people, one of whom is an Employee of the Policyholder, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

NOTICE FOR RESIDENTS OF WASHINGTON

LIFE INSURANCE

GENERAL PROVISIONS

The suicide provision is not applicable to residents of Washington.

NOTICE FOR RESIDENTS OF WASHINGTON

This non-insurance benefit does not constitute an insurance funded prearrangement contract, pursuant to RCW 18.39.255.

Employees who become insured for MetLife Supplemental Life Insurance and/or non-contributory Basic Life Insurance under the Group Policy are eligible to receive discounts of up to 10% off the service provider's standard price for certain funeral services including funeral, cremation and cemetery products and services provided by a third party national network of funeral and funeral planning providers while such insurance remains in effect. Employees who become insured for MetLife Supplemental Life Insurance and/or non-contributory Basic Life Insurance will also have access to funeral planning resources including funeral planning tools and concierge services provided by the same national network of providers. MetLife has arranged for these services and discounts to be provided to Employees and their spouses for no additional premium. MetLife is not responsible for providing or failing to provide these services nor is it liable for any negligence in the provision of such services by the third party service provider.

The discounts and planning services are not available in all jurisdictions and are subject to regulatory approval.

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If You are having problems with Your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve Your problem.

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, New York 10166
1-800-638-6420

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.

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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents will only be insured for the benefits:

- for which You and Your Dependents become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

The amount of Insurance that We will pay for any insurance to which You make contributions will be decreased by the amount of Your contributions due and unpaid to Us for that insurance.

BENEFIT	BENEFIT AMOUNTS AND HIGHLIGHTS

Life Insurance For You

Basic Life Insurance

Basic Life Insurance is **NOT** Portability Eligible Insurance

For all Full-Time Hourly Employees:

For Active Employees	$10,000
Accelerated Benefit Option.....	Up to 80% of Your Basic Life amount not to exceed $8,000

For all Full-Time Salary Employees:

For Active Employees	$25,000
Accelerated Benefit Option.....	Up to 80% of Your Basic Life amount not to exceed $20,000

Supplemental Life Insurance

Supplemental Life Insurance is Portability Eligible Insurance

For Active Employees.....	An amount, elected by You, which is a multiple of $10,000
Minimum Supplemental Life Benefit.....	$10,000
Maximum Supplemental Life Benefit	The lesser of 7 times Your Basic Annual Earnings or $500,000
Non-Medical Issue Amount	$380,000
Accelerated Benefit Option.....	Up to 80% of Your Supplemental Life amount not to exceed $400,000

SCHEDULE OF BENEFITS (continued)

ESTATE RESOLUTION SERVICES

The following Estate Resolution Services are provided at no additional cost to individuals insured for Group Supplemental Life Insurance coverage as described below. If You are eligible to receive these Estate Resolution Services and You or Your Spouse (for the Will Preparation Service) or You or Your Spouse or a Beneficiary (for the Probate Service) would like to speak with a representative from MetLife Legal Plans or get the name of a Plan Attorney that you can speak with about these Services, please call (800) 821-6400.

Will Preparation Service

If You elect Group Supplemental Life Insurance coverage, a Will Preparation Service (the "Service") will be made available to You through a MetLife affiliate (the "Affiliate"), as agreed to by the Policyholder and MetLife, while Your Group Supplemental Life Insurance coverage is in effect under this Policy.

Will Preparation Service means a service covering the preparation of wills and codicils for You and Your Spouse. The creation of any testamentary trust is covered. The Will Preparation Service does not include tax planning.

This Service will be made available at no cost to You. It enables You to have a will prepared for You and Your Spouse free of charge by attorneys designated by the Affiliate. If You have a will prepared by an attorney not designated by the Affiliate, You must pay for the attorney's services directly. Upon Proof of such payment, You will be reimbursed for the attorney's services in an amount equal to the lesser of the amount You paid for the attorney's services and the amount customarily reimbursed for such services by the Affiliate.

Probate Service

If You become insured for Group Supplemental Life Insurance coverage and You or Your Spouse die while such Group Supplemental Life Insurance coverage is in effect, a probate benefit (the "Benefit") will be made available to Your estate in the event of Your death or to Your Spouse's estate in the event of Your Spouse's death. Such benefit will be made available through a MetLife affiliate ("Affiliate").

The Benefit includes attorney representation and payment of legal fees for the executor or administrator of the estate of the deceased including representation for the preparation of all documents and all of the court proceedings needed to transfer probate assets from the estate of the deceased to applicable heirs; and the completion of correspondence necessary to transfer non-probate assets such as proceeds from insurance policies, joint bank accounts, stock accounts or a house; and associated tax filings.

The Benefit provides for such services to be made available, free of charge by attorneys designated by the Affiliate. If probate services are provided by an attorney not designated by the Affiliate, the estate of the deceased must pay for those attorney's services directly. Upon Proof of such payment, the estate of the deceased will be reimbursed for the attorney's services in an amount equal to the lesser of the amount such estate paid for the attorney's services and the amount customarily reimbursed for such services by the Affiliate.

This Benefit will be provided at no cost to You and will end on the date Your Group Supplemental Life Insurance coverage ends.

Accidental Death and Dismemberment Insurance (AD&D) For You

Accidental Death and Dismemberment Insurance for You is NOT Portability Eligible Insurance

For all Full-Time Hourly Employees:

For Active Employees	An amount equal to Your Basic Life Insurance
Maximum Accidental Death and Dismemberment Full Amount	$10,000

For all Full-Time Salary Employees:

For Active Employees	An amount equal to Your Basic Life Insurance
Maximum Accidental Death and Dismemberment Full Amount	$25,000

Additional Benefits:

Seat Belt Benefit	Yes
Air Bag Use Benefit	Yes
Child Care Benefit	Yes
Child Education Benefit	Yes
Spouse Education Benefit	Yes
Hospital Confinement Benefit	Yes
Common Carrier Benefit	Yes
Repatriation Expense Benefit	Yes

The Common Carrier Benefit is an amount equal to the Full Amount.

Schedule of Covered Losses for Accidental Death and Dismemberment Insurance

All amounts listed are stated as percentages of the Full Amount.

Covered Losses

Loss of life	100%
Loss of a hand permanently severed at or above the wrist but below the elbow	50%
Loss of a foot permanently severed at or above the ankle but below the knee	50%

SCHEDULE OF BENEFITS (continued)

Loss of an arm permanently severed at or above the elbow	75%
Loss of a leg permanently severed at or above the knee	75%
Loss of sight in one eye	50%

Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.

Loss of any combination of hand, foot, or sight of one eye, as defined above	100%
Loss of the thumb and index finger of same hand	25%

Loss of thumb and index finger of same hand means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

Loss of speech and loss of hearing	100%
Loss of speech or loss of hearing	50%

Loss of speech means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury.

Loss of hearing means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.

Paralysis of both arms and both legs	100%
Paralysis of both legs	50%
Paralysis of the arm and leg on either side of the body	50%
Paralysis of one arm or leg	25%

Paralysis means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete and irreversible.

Brain Damage	100%

Brain Damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least 5 days and persists for 12 consecutive months after the date of the accidental injury.

Coma	1% monthly beginning on the 7th day of the Coma for the duration of the Coma to a maximum of 60 months

Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.

Third-degree burn(s)	A percentage of the Full Amount equal to the percentage of body surface suffering third-degree burns

SCHEDULE OF BENEFITS (continued)

Life Insurance For Your Dependents

Life Insurance for Your Dependents is Portability Eligible Insurance

For Your Spouse.....	An amount, elected by You, which is a multiple of $5,000
Minimum Spouse Dependent Life Benefit	$5,000
Maximum Spouse Dependent Life Benefit ……..	The lesser of 50% of Your Supplemental Life Benefits or $100,000
Non-Medical Issue Amount ……	$30,000
Accelerated Benefit Option	Up to 80% of Your Dependent Life amount not to exceed $80,000

For each of Your Children:

Under 6 months old…..…….……..	$1,000
6 months and older……..	An amount, elected by You, which is a multiple of $5,000
Minimum Child Dependent Life Benefit……...	$1,000
Maximum Child Dependent Life Benefit……...	$25,000

If You Are Age 65 Or Older (Not applicable to Continuation Eligible Insurance described in the section entitled ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED)

If You are age 65 or older on Your effective date of insurance, the appropriate percentage from the following table will be applied to the amount of Your Basic Life, Supplemental Life, Accidental Death and Dismemberment and Dependent Life Insurance on Your effective date of insurance.

If You are under age 65 on Your effective date of insurance, the amounts of Your Basic Life, Supplemental Life, Accidental Death and Dismemberment and Dependent Life Insurance on and after age 65 will be determined by applying the appropriate percentage from the following table to the amount of Your insurance in effect on the day before Your 65th birthday. The reduced amount will take effect on the following January 1st following attainment of age.

Age of Employee	Percentage
65	65%
70	45%

Portability Eligible Life Insurance

Life Insurance For You:

Portability Eligible Life Insurance For You:

Minimum Portability Eligible Life Insurance Amount……	$10,000
Maximum Portability Eligible Life Insurance Amount……..	The lesser of Your total Life Insurance in effect on the date You elect to Port or $2,000,000

If Your Portability Eligible Insurance ends due to the end of the Group Policy or the amendment of the Group Policy to end the Portability Eligible Insurance for an eligible class of which You are a member, the maximum amount of insurance that You may Port is the lesser of:

- the amount of Your Portability Eligible Insurance that ends under the Group Policy less the amount of life insurance for which You become eligible under any group policy issued to replace this Group Policy; or
- $10,000.

Life Insurance For Your Spouse:

Portability Eligible Dependent Spouse Life Insurance:

Minimum Portability Eligible Dependent Spouse Life Insurance Amount	$2,500 ($10,000 when porting Dependent Spouse Life Insurance alone)
Maximum Portability Eligible Dependent Spouse Life Insurance Amount	The lesser of Your total Dependent Spouse Life Insurance in effect on the date You elect to Port or $250,000

If Your Portability Eligible Insurance or Your Portability Eligible Dependent Insurance ends due to the end of the Group Policy or the amendment of the Group Policy to end the Portability Eligible Insurance or Your Portability Eligible Dependent Insurance for an eligible class of which You are a member, the maximum amount of insurance that You may Port is the lesser of:

- the amount of Your Portability Eligible Insurance or Your Portability Eligible Dependent Insurance that ends under the Group Policy less the amount of life insurance for which You become eligible under any group policy issued to replace this Group Policy; or
- $10,000.

Life Insurance For Your Children:

Portability Eligible Dependent Child Life Insurance:

Minimum Portability Eligible Dependent Child Life Insurance Amount……..	$1,000
Maximum Portability Eligible Dependent Child Life Insurance Amount……..	The lesser of Your total Dependent Child Life Insurance in effect on the date You elect to Port or $25,000

If Your Portability Eligible Insurance or Your Portability Eligible Dependent Insurance ends due to the end of the Group Policy or the amendment of the Group Policy to end the Portability Eligible Insurance or Your Portability Eligible Dependent Insurance for an eligible class of which You are a member, the maximum amount of insurance that You may Port is the lesser of:

- the amount of Your Portability Eligible Insurance or Your Portability Eligible Dependent Insurance that ends under the Group Policy less the amount of life insurance for which You become eligible under any group policy issued to replace this Group Policy; or

- $10,000.

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a full-time basis. This must be done at:

- the Policyholder's place of business;
- an alternate place approved by the Policyholder; or
- a place to which the Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Policyholder approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Basic Annual Earnings means:

- **for commission employees,** gross annual rate of pay as determined by Your Policyholder based on the most recent W-2, or if service of less than one year, the average paid for the period worked.
- **for all other employees,** gross annual rate of pay as determined by Your Policyholder based on the average monthly wages from the prior October 1 through September 30.

Beneficiary means the person(s) to whom We will pay insurance as determined in accordance with the GENERAL PROVISIONS section.

Child means the following:

for Life Insurance, Your natural child, adopted child or stepchild; and who, in each case, is under age 26.

The term also includes Your grandchild who is under age 26 and who was able to be claimed by You as a dependent for Federal Income Tax purposes at the time You applied for Life Insurance.

A child will be considered Your adopted child during the period You are party to a suit in which You are seeking the adoption of the child.

For the purposes of determining who may become covered for insurance, the term also does not include any person who:

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.

Common Carrier means a government regulated entity that is in the business of transporting fare paying passengers.

The term does not include:

- chartered or other privately arranged transportation;
- taxis; or
- limousines.

Contributory Insurance means insurance for which the Policyholder requires You to pay any part of the premium.

Contributory Insurance includes: Supplemental Life Insurance and Dependent Life Insurance.

If You enroll for certain Contributory Insurance, a portion of Your contributions for such insurance will be allocated to reduce the Policyholder's cost of certain Noncontributory Insurance under the Group Policy.

DEFINITIONS (continued)

Dependent(s) means Your Spouse and/or Child.

Full-Time means Active Work of at least 30 hours per week on the Policyholder's regular work schedule for the eligible class of employees to which You belong.

Hospital means a facility which is licensed as such in the jurisdiction in which it is located and:

- provides a broad range of medical and surgical services on a 24 hour a day basis for injured and sick persons by or under the supervision of a staff of Physicians; and
- provides a broad range of nursing care on a 24 hour a day basis by or under the direction of a registered professional nurse.

Hospitalized means:

- admission for inpatient care in a Hospital;
- receipt of care in the following:
  - a hospice facility;
  - an intermediate care facility; or
  - a long term care facility; or
- receipt of the following treatment, wherever performed:
  - chemotherapy;
  - radiation therapy; or
  - dialysis.

Noncontributory Insurance means insurance for which the Policyholder does not require You to pay any part of the premium.

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. Such person must also be certified and/or registered if required by such jurisdiction.

The term does not include:

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse's:
  - parents;
  - children (natural, step or adopted);
  - siblings;
  - grandparents; or
  - grandchildren.

DEFINITIONS (continued)

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Spouse means Your lawful spouse.

For the purposes of determining who may become covered for insurance, the term does not include any person who:

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.

We, Us and **Our** mean MetLife.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

You and **Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

Class 1: Full-time hourly and salary employees who are employed by the Policyholder and who are classified by the Policyholder as Full-Time Employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder.

Class 2: Variable hour employees who are employed by the Policyholder and who are employees of the Policyholder who qualify as Full-Time Employees based on working an average of 30 hours or more per week during a particular Measurement Period.

Full-Time Employee means an employee who qualifies as full-time under the following eligibility rules:

There are 2 categories of Full-Time Employees:

- Employees of the Policyholder who are classified by the Policyholder as full-time regular employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder.
- Employees of the Policyholder who are variable hour employees that qualify as Full-Time Employees based on working 30 hours or more per week during a particular Measurement Period.

See also Eligibility Definitions below.

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

For Eligible Class 1

If You are in an eligible class on January 1, 2021, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after January 1, 2021, You will be eligible for insurance on the day after the date You complete the Waiting Period of 89 days.

Changing from either hourly to salaried or salaried to hourly will not require a new waiting period and any waiting period days already satisfied will still apply.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

Your eligibility for insurance will continue, subject to the Date Your Insurance Ends section, until such time as Your employment ends or Your employment classification changes to a non-full-time status, as determined by the Policyholder based upon status classification changes and/or a reduction in hours worked.

For Eligible Class 2

Eligibility Rules – Newly Hired Employees Who Are Hired on or After January 1, 2021

If on the date of Your hire, You are classified as a variable hour employee by the Policyholder, You may later qualify for Full-Time Employee status if the Policyholder determines that You have worked an average of 30 or more hours per week during the Initial Measurement Period. If You qualify for Full-Time Employee status during the Initial Measurement Period, You will be eligible for insurance during the Initial Stability Period, provided that Your employment continues. Your eligibility for insurance will terminate, subject to the Date Your Insurance Ends section, at the end of the Initial Stability Period, unless the Policyholder determines that You re-qualify for Full-Time Employee status during an Ongoing Measurement Period.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

Eligibility Rules – Ongoing Employees

If You are classified on or after January 1, 2021 as a variable hour employee by the Policyholder following Your Initial Stability Period, You must work an average of 30 hours or more per week during any Ongoing Measurement Period. Your eligibility for insurance will terminate, subject to the Date Your Insurance Ends section, at the end of the Ongoing Stability Period, unless the Policyholder determines that You re-qualify for Full-Time Employee status during an Ongoing Measurement Period.

If You were not initially classified as a variable hour employee by the Policyholder on Your date of hire the following eligibility rules apply on and after January 1, 2021 regardless of whether You were eligible for insurance during the Initial Stability Period:

If You qualify for Full-Time Employee status by working an average of 30 or more hours per week as determined by the Policyholder during any Ongoing Measurement Period You will be eligible for insurance during the immediately following Ongoing Stability Period, provided that Your employment continues. Your eligibility for insurance will terminate, subject to the Date Your Insurance Ends section, at the end of the Ongoing Stability Period, unless the Policyholder determines that You re-qualify for Full-Time Employee status during an Ongoing Measurement Period.

Eligibility Definitions

For purposes of the above eligibility rules, the following terms and their meanings are indicated.

Initial Measurement Period means a period that starts with the first pay period that begins immediately after Your hire date, and ends on the last day of the pay period that contains the eleventh (11th) month anniversary of Your hire.

Initial Stability Period means a 12 month period that starts on the first day of the 13th calendar month following Your date of hire.

Ongoing Measurement Period means an annual 12 month period that starts on October 15th.

Ongoing Stability Period means the 12 month period that starts on the first day of the calendar year following the end of the immediately preceding Ongoing Measurement Period.

Previous Employment With The Policyholder

If You were employed by the Policyholder and insured by Us under a policy of group life insurance when Your employment ended, You will not be eligible for life insurance under this Group Policy if You are re-hired by the Policyholder within 2 years after such employment ended, unless You surrender:

- any individual policy of life insurance to which You converted when Your employment ended; and
- any certificate of insurance continued as ported insurance when such employment ended.

The cash value, if any, of such surrendered insurance will be paid to You.

ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the required form. In addition, You must give evidence of Your Insurability satisfactory to Us at Your expense if You are required to do so under the section entitled EVIDENCE OF INSURABILITY. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

The insurance listed below is part of a flexible benefits plan established by the Policyholder. Subject to the rules of the flexible benefits plan and the Group Policy, You may enroll for:

- Supplemental Life Insurance

only when You are first eligible or during an annual enrollment period or if You have a Qualifying Event. You should contact the Policyholder for more information regarding the flexible benefits plan.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

DATE YOUR INSURANCE THAT IS PART OF THE FLEXIBLE BENEFITS PLAN TAKES EFFECT

Enrollment When First Eligible

For new hires, if You complete the enrollment process within 89 days of becoming eligible for Supplemental Insurance, such insurance will take effect as follows:

If You are in Eligible Class 1, i.e., You are a full-time regular employee, and are **not required** to give evidence of Your insurability, such insurance will take effect on the date You become eligible, provided You are Actively at Work in Eligible Class 1 on that date.

If You are in Eligible Class 1 and are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, provided You are Actively at Work on that date.

If You are in Eligible Class 2, i.e., You are a variable hour employee who has qualified for Full-Time Employee status by working an average of 30 hours or more per week as determined by the Policyholder during Your Initial Measurement Period and are **not required** to give evidence of Your insurability, such insurance will take effect on the later of:

1. January 1, 2021; and
2. the first day of the Initial Stability Period

provided You are Actively at Work in Eligible Class 2 on that date.

If You are in Eligible Class 2 and are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, provided You are Actively at Work on that date.

If You are in Eligible Class 2 and have qualified for Full-Time Employee status by working an average of 30 hours or more per week as determined by the Policyholder during an Ongoing Measurement Period and for any amount of insurance for which You are **not required** to give evidence of insurability, such amount of insurance will take effect on the first day of the immediately following Ongoing Stability Period provided You are Actively at Work in Eligible Class 2 on that date.

If You are in Eligible Class 2 and have qualified for Full-Time Employee status by working an average of 30 hours or more per week as determined by the Policyholder during an Ongoing Measurement Period and for any amount of insurance for which You are **required** to give evidence of insurability, such amount of insurance will take effect on the date We state in Writing, provided You are Actively at Work in Eligible Class 2 on that date.

If You do not complete the enrollment process within 89 days of becoming eligible, You will not be able to enroll for insurance until the next annual enrollment period, as determined by the Policyholder, following the date You first became eligible, unless You have a Qualifying Event. At that time You will be able to enroll for insurance for which You are then eligible.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work. In addition to having been Actively at Work on the date Your Contributory Life Insurance benefit is to take effect, You must also have been Actively at Work for at least 20 hours during the 7 calendar days preceding that date.

Enrollment During An Annual Enrollment Period

During any annual enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible or choose a different option than the one for which You are currently enrolled. The insurance enrolled for or changes to Your insurance made during an annual enrollment period will take effect as follows:

- for any amount for which You are **not required** to give evidence of Your insurability, such insurance will take effect on the first day of the calendar year following the annual enrollment period, if You are Actively at Work on that date.

- for any amount for which You are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, if You are Actively at Work on that date.

If You are not Actively at Work on the date an amount of insurance would otherwise take effect, that amount of insurance will take effect on the day You resume Active Work. For a Contributory Life Insurance Benefit to take effect, in addition to having been Actively at Work on the date the insurance benefit is to take effect, You must also have been Actively at Work for at least 20 hours during the 7 calendar days preceding that date.

Enrollment Due to a Qualifying Event

Under the rules of the flexible benefit plan, You may enroll for insurance for which You are eligible or change the amount of Your insurance between annual enrollment periods only if You have a Qualifying Event.

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for, or changes to Your insurance made as a result of a Qualifying Event will take effect as follows:

- for any amount for which You are **not required** to give evidence of Your insurability, such insurance will take effect on the date of the Qualifying Event, if You are Actively at Work on that date.
- for any amount for which You are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, if You are Actively at Work on that date.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work. For a Contributory Life Insurance Benefit to take effect, in addition to having been Actively at Work on the date the insurance benefit is to take effect, You must also have been Actively at Work for at least 20 hours during the 7 calendar days preceding that date.

DATE YOUR INSURANCE THAT IS NOT PART OF THE FLEXIBLE BENEFITS PLAN TAKES EFFECT

Rules for Noncontributory Insurance

Noncontributory Insurance will take effect as follows:

If You are in Eligible Class 1, i.e., You are a full-time regular employee, the Non-Contributory Insurance described in this certificate will take effect on the date You become eligible, provided You are Actively at Work in Eligible Class 1 on that date.

If You are in Eligible Class 2, i.e., You are a variable hour employee who has qualified for Full-Time Employee status by working an average of 30 hours or more per week as determined by the Policyholder during Your Initial Measurement Period, the insurance described in this certificate will take effect on the later of:

1. January 1, 2021; and
2. the first day of the Initial Stability Period

provided You are Actively at Work in Eligible Class 2 on that date.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

If You are a variable hour employee who has qualified for Full-Time Employee status by working an average of 30 hours or more per week as determined by the Policyholder during an Ongoing Measurement Period, the Noncontributory Insurance described in this certificate will take effect on the first day of the immediately following Ongoing Stability Period, provided You are Actively at Work in Eligible Class 2 on that date.

If You are not Actively at Work in an Eligible Class on the date the Noncontributory Insurance would otherwise take effect, the benefit will take effect on the day You resume Active Work in an Eligible Class.

FOR SUPPLEMENTAL LIFE INSURANCE

Increase in Insurance

An increase in insurance due to an increase in Your earnings will take effect on October 1st of each year following the date of the increase in Your earnings.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Decrease in Insurance

A decrease in insurance due to a decrease in Your earnings will take effect on October 1st of each year following the date of decrease in Your earnings.

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends; or
2. the date insurance ends for Your class; or
3. the date You cease to be in an eligible class; or
4. the end of the period for which the last premium has been paid for You; or
5. the last day of the month following the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
6. the date You retire in accordance with the Policyholder's retirement plan; or
7. the date You cease to be Actively at Work in Eligible Class 1 and provided that You have not become eligible as a variable hour employee under Eligible Class 2, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
8. the end of the last Stability Period for which You have been determined by the Policyholder to be a variable hour employee as a member of Eligible Class 2 due to Your work in a prior Measurement Period and provided that You have not become eligible as a full-time regular employee under Eligible Class 1, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

Please refer to the section entitled ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED for information concerning continuation of Your Life Insurance if insurance ends while You are Totally Disabled. Please refer to the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU for information concerning the option to convert to an individual policy of life insurance if Your Life Insurance ends.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

Class 1: Full-time hourly and salary employees who are employed by the Policyholder and who are classified by the Policyholder as Full-Time Employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder.

Class 2: Variable hour employees who are employed by the Policyholder and who are employees of the Policyholder who qualify as Full-Time Employees based on working an average of 30 hours or more per week during a particular Measurement Period.

Full-Time Employee means an employee who qualifies as full-time under the following eligibility rules: There are 2 categories of Full-Time Employees:

- Employees of the Policyholder who are classified by the Policyholder as full-time regular employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder.
- Employees of the Policyholder who are variable hour employees that qualify as Full-Time Employees based on working 30 hours or more per week during a particular Measurement Period.

See also Eligibility Definitions below.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

For Eligible Class 1

You may only become eligible for the Dependent insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

You will be eligible for Dependent insurance described in this certificate on the latest of:

1. January 1, 2021;
2. the date You enter a class eligible for insurance;
3. the date You obtain a Dependent; and
4. the day after the date You complete the Waiting Period of 89 days.

Changing from either hourly to salaried or salaried to hourly will not require a new waiting period and any waiting period days already satisfied will still apply.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

Your eligibility for insurance will continue, subject to the Date Your Insurance For Your Dependents Ends section, until such time as Your employment ends or the date on which You no longer have any Dependents or the date on which Your employment classification changes to a variable hour employee as determined by the Policyholder based upon status classification changes and/or a reduction in hours worked.

No person may be insured as a Dependent of more than one employee.

For Eligible Class 2

Eligibility Rules – Newly Hired Employees Who Are Hired on or After January 1, 2021

If on the date of Your hire, You are classified as a variable hour employee by the Policyholder, You may later qualify for Full-Time Employee status if the Policyholder determines that You have worked an average of 30 or more hours per week during the Initial Measurement Period. If You qualify for Full-Time Employee status during the Initial Measurement Period and if You have a Dependent, You will be eligible for insurance during the Initial Stability Period, provided that Your employment continues. Your eligibility for Insurance for Your Dependents will terminate when You no longer have any Dependents.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

If earlier, Your eligibility for Insurance for Your Dependents will terminate subject to the Date Your Insurance For Your Dependents Ends section, or at the end of the Initial Stability Period, unless the Policyholder determines that You re-qualify for Full-Time Employee status during an Ongoing Measurement Period.

No person may be insured as a Dependent of more than one employee.

Eligibility Rules – Ongoing Employees

If You are a variable hour employee and were not initially classified or designated as a full-time regular employee by the Policyholder on Your date of hire the following eligibility rules apply regardless of whether You were eligible for insurance during the Initial Stability Period:

If You qualify for Full-Time Employee status by working an average of 30 or more hours per week as determined by the Policyholder during any Ongoing Measurement Period and if You have a Dependent You will be eligible for insurance during the immediately following Ongoing Stability Period, provided that Your employment continues. Your eligibility for Insurance for Your Dependents will terminate subject to the Date Your Insurance For Your Dependents Ends section, or at the end of the Ongoing Stability Period, unless the Policyholder determines that You re-qualify for Full-Time Employee status during an Ongoing Measurement Period.

Eligibility Definitions

For purposes of the above eligibility rules, the following terms and their meanings are indicated.

Initial Measurement Period means a period that starts with the first pay period that begins immediately after Your hire date, and ends on the last day of the pay period that contains the eleventh (11th) month anniversary of Your hire.

Initial Stability Period means a 12 month period that starts on the first day of the 13th calendar month following Your date of hire.

Ongoing Measurement Period means an annual 12 month period that starts on October 15th.

Ongoing Stability Period means the 12 month period that starts on the first day of the calendar year following the end of the immediately preceding Ongoing Measurement Period.

No person may be insured as a Dependent of more than one employee.

ENROLLMENT PROCESS

In order to enroll for Life Insurance for Your Dependents, You must either (a) already be enrolled for Supplemental Life Insurance for You or (b) enroll at the same time for Supplemental Life Insurance for You.

If You become eligible for Dependent insurance, You may enroll for such insurance by providing Us with the information We require for each Dependent to be insured. In addition, each of Your Dependents must give evidence of insurability satisfactory to Us at Your expense if required to do so under the section entitled EVIDENCE OF INSURABILITY. If You enroll for Contributory Insurance, You must also give the Policyholder written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

Once You have enrolled one Child for a Dependent insurance benefit, each succeeding Child will automatically be covered for such insurance on the date that Child qualifies as a Dependent.

The insurance listed below is part of a flexible benefits plan established by the Policyholder. Subject to the rules of the flexible benefits plan and the Group Policy, You may enroll for:

- Dependent Life Insurance;

only when You are first eligible or during an annual enrollment period or if You have a Qualifying Event. You should contact the Policyholder for more information regarding the flexible benefits plan.

DATE INSURANCE THAT IS PART OF THE FLEXIBLE BENEFITS PLAN TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

For new hires, if You complete the enrollment process within 89 days of becoming eligible for Dependent Insurance, such insurance will take effect as follows:

If You are in Eligible Class 1, i.e., You are a full-time regular employee and the Dependent is **not required** to give evidence of insurability, such insurance will take effect on the date You become eligible, provided You are Actively at Work in Eligible Class 1 on that date and the Dependent satisfies the Additional Requirement stated below.

If You are in Eligible Class 1 and the Dependent is **required** to give evidence of insurability, such insurance will take effect on the date We state in Writing, provided You are Actively at Work on that date, and the Dependent satisfies the Additional Requirement stated below.

If You are in Eligible Class 2, i.e., You are a variable hour employee who has qualified for Full-Time Employee status by working an average of 30 hours or more per week as determined by the Policyholder during Your Initial Measurement Period and the Dependent is **not required** to give evidence of insurability, such insurance will take effect on the later of:

1. January 1, 2021; and
2. the first day of the Initial Stability Period

provided that person is Your Dependent on that date, You are Actively at Work in Eligible Class 2 on that date, and the Dependent satisfies the Additional Requirement stated below.

If You are in Eligible Class 2 and the Dependent is **required** to give evidence of insurability, such insurance will take effect on the date We state in Writing, provided that person is Your Dependent on that date, You are Actively at Work in Eligible Class 2 on that date, and the Dependent satisfies the Additional Requirement stated below.

If You are in Eligible Class 2 and have qualified for Full-Time Employee status by working an average of 30 hours or more per week as determined by the Policyholder during an Ongoing Measurement Period and the Dependent is **not required** to give evidence of insurability, such insurance will take effect on the first day of the immediately following Ongoing Stability period provided that person is Your Dependent on that date, You are Actively at Work in Eligible Class 2 on that date, and the Dependent satisfies the Additional Requirement stated below.

If You are in Eligible Class 2 and have qualified for Full-Time Employee status by working an average of 30 hours or more per week as determined by the Policyholder during an Ongoing Measurement Period and the Dependent is **required** to give evidence of insurability, such insurance will take effect on the date We state in Writing, provided that person is Your Dependent on that date, You are Actively at Work in Eligible Class 2 on that date, and the Dependent satisfies the Additional Requirement stated below.

Once You have enrolled one Child for a Dependent insurance benefit, each succeeding Child will automatically be covered for such insurance on the date that Child qualifies as a Dependent.

If You do not complete the enrollment process for any Dependent within 31 days of becoming eligible, You will not be able to enroll for Dependent insurance until the next annual enrollment period, as determined by the Policyholder, in accordance with the rules of the flexible benefits plan. At that time You will be able to enroll for Dependent insurance:

- for which You are then eligible; and
- for Your Dependents who are then eligible.

If You are not Actively at Work on the date Dependent insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Enrollment During An Annual Enrollment Period

During any annual enrollment period, You may enroll for Dependent insurance for which You are eligible or change the amount of Your Dependent insurance. The insurance enrolled for or changes to Your insurance made during the annual enrollment period will take effect for each enrolled Dependent as follows:

- if the Dependent is **not required** to give evidence of insurability, such insurance will take effect on the first day of the calendar year following the annual enrollment period, if You are Actively at Work on that date and the Dependent satisfies the Additional Requirement stated below.

- if the Dependent is **required** to give evidence of insurability and We determine that the Dependent is insurable, such insurance will take effect on the date We state in Writing, if You are Actively at Work on that date and the Dependent satisfies the Additional Requirement stated below.

Once You have enrolled one Child for a Dependent insurance benefit, each succeeding Child will automatically be covered for such insurance on the date that Child qualifies as a Dependent.

If You are not Actively at Work on the date Dependent insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Enrollment Due to a Qualifying Event

Under the rules of the flexible benefit plan, You may enroll for Dependent insurance for which You are eligible or change the amount of Your Dependent insurance between annual enrollment periods only if You have a Qualifying Event.

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect for each enrolled Dependent as follows:

- if the Dependent is **not required** to give evidence of insurability, such insurance will take effect on the date of the Qualifying Event, if You are Actively at Work on that date and the Dependent satisfies the Additional Requirement stated below.

- if the Dependent is **required** to give evidence of insurability and We determine that the Dependent is insurable, such insurance will take effect on the date We state in Writing, if You are Actively at Work on that date and the Dependent satisfies the Additional Requirement stated below.

Once You have enrolled one Child for a Dependent insurance benefit, each succeeding Child will automatically be covered for such insurance on the date that Child qualifies as a Dependent.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Additional Requirement

On the date Dependent insurance is scheduled to take effect, the Dependent must not be:

- confined at home under a Physician's care;
- receiving or applying to receive disability benefits from any source; or
- Hospitalized.

If the Dependent does not meet this requirement on such date, insurance for the Dependent will take effect on the date that Dependent is no longer:

- confined;
- receiving or applying to receive disability benefits from any source; or
- Hospitalized.

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

A Dependent's insurance will end on the earliest of:

1. the date all of the Life Insurance under the Group Policy ends; or
2. the date You die; or
3. the date the Group Policy ends; or
4. the date You cease to be in an eligible class; or
5. the date Your Employee Life Insurance under the Group Policy ends; or
6. the date Insurance for Your Dependents ends under the Group Policy; or
7. the date Insurance for Your Dependents ends for Your class; or
8. the date the person ceases to be a Dependent; or
9. the last day of the month following the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
10. the date You retire in accordance with the Policyholder’s retirement plan; or
11. for a Child who is past the age limit and is otherwise eligible for continuation under the **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT: For Mentally or Physically Handicapped Children** subsection, on the date the Child marries; or
12. the end of the period for which the last premium has been paid for the Dependent; or
13. the date You cease to be Actively at Work in Eligible Class 1 and provided that You have not become eligible as a variable hour employee under Eligible Class 2, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
14. the end of the last Stability Period for which You have been determined by the Policyholder to be a variable hour employee as a member of Eligible Class 2 due to Your work in a prior Measurement Period and provided that You have not become eligible as a full-time regular employee under Eligible Class 1, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

Please refer to the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS for information concerning the option to convert to an individual policy of life insurance if Life Insurance for a Dependent ends.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP LIFE AND AD&D INSURANCE

The following rules will apply if the Life and AD&D Insurance under this Group Policy replaces other group Life and AD&D insurance provided to You by the Policyholder.

Prior Plan means the group life and AD&D insurance underwritten by another insurer and provided to You by the Policyholder on the day before the Replacement Date.

Replacement Date means the effective date of the Life and AD&D Insurance under this Group Policy.

Rules if You and Your Dependents were Covered Under the Prior Plan on the Day Before the Replacement Date:

1. **Actively at Work on the Replacement Date** - If You and Your Dependent(s) were covered under the Prior Plan on the day before the Replacement Date and You are Actively at Work in an eligible class on the Replacement Date, You will be insured under this Group Policy for an amount of Life and AD&D Insurance referred to as Active Employee Coverage. The amount of the Active Employee Coverage on the Replacement Date will be the amount of Life Insurance described in the SCHEDULE OF BENEFITS.

2. **Not Actively at Work on the Replacement Date -** If You and Your Dependent(s) were covered under the Prior Plan on the day before the Replacement Date and You are not Actively at Work on the Replacement Date, but You would otherwise be a member of an eligible class if You were Actively at Work on the Replacement Date, You will be insured under this Group Policy for an amount of Life and AD&D Insurance referred to as Transition Coverage. The amount of the Transition Coverage on the Replacement Date will be the lesser of:

   - the amount of group life and AD&D insurance in effect under the Prior Plan, and
   - the amount of Life and AD&D Insurance available under this Group Policy for the eligible class to which You belong.

   While Transition Coverage is in effect, the amount of coverage will continue to be determined in accordance with the provisions of the plan used to determine the amount of Transition Coverage on the Replacement Date.

   If You are not Actively at Work on the Replacement Date due to a disability, Transition Coverage will remain in effect on and after the Replacement Date until the earliest of:

   - the date You return to Active Work as a member of an eligible class, at which time Active Employee Coverage will supersede the Transition Coverage;
   - the date Life and AD&D Insurance would otherwise end in accordance with the terms and conditions of this certificate;
   - the date on which Your life and AD&D insurance under the Prior Plan would have ended for any reason other than the Prior Plan ending;
   - the date You are approved for extension of life and AD&D insurance without premium payment under the terms of Prior Plan; and
   - if the Prior Plan provided for extension of life and AD&D insurance without premium payment during a period of disability, the last day of the 12-month period following the Replacement Date.

SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP LIFE AND AD&D INSURANCE (continued)

In any other case where You are not Actively at Work on the Replacement Date, Transition Coverage will remain in effect on and after the Replacement Date until the earliest of:

- the date You return to Active Work as a member of an eligible class, at which time Active Employee Coverage will supersede the Transition Coverage; and
- the date Life and AD&D Insurance would otherwise end in accordance with the terms and conditions of this certificate.

Rules if You and Your Dependents were NOT Covered Under the Prior Plan on the Day Before the Replacement Date:

1. You will be eligible for the Life and AD&D Insurance under this Group Policy when You meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOU and ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS; and

2. We will credit any time accumulated toward any eligibility waiting period under the Prior Plan to the satisfaction of any eligibility Waiting Period required to be met under this Life and AD&D Insurance.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (For MN Residents see Minnesota Notice Page)

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Child attains the age limit and at reasonable intervals after such date, but not more frequently than once a year after the two-year period following the child's attainment of the limiting age.

Subject to the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, insurance will continue while such Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Child, except for the age limit.

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Policyholder for information regarding such legally mandated leave of absence laws.

AT YOUR OPTION: PORTABILITY

For Life Insurance

If Your Portability Eligible Insurance or Portability Eligible Dependent Insurance ends for any of the reasons stated below, You have the option to continue that insurance under another group policy in accordance with the conditions and requirements of this section. This is referred to as Porting. Evidence of Your insurability will not be required.

For purposes of this subsection the term "Portability Eligible Insurance" refers to Your Life Insurance benefits for which the Portability Eligible Insurance is shown as available in the SCHEDULE OF BENEFITS.

If Insurance for Your Dependents is in effect, the term "Portability Eligible Dependent Insurance" refers to Your Life Insurance for Your Dependents for which the Portability Eligible Dependent Insurance is shown as available in the SCHEDULE OF BENEFITS.

When Porting is an Option

Porting may only be exercised by a request in Writing during the Request Period specified below.

If You choose not to Port, Life Insurance benefits may be converted in accordance with the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU or the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS.

1. You may choose to Port if Portability Eligible Insurance and/or Portability Eligible Dependent Insurance ends because:
    - You become retired from active service with the Employer; or
    - Your employment ends, due to a reason other than retirement; or
    - You cease to be in a class that is eligible for such insurance; or
    - the Policy is amended to end the Portability Eligible Insurance or Portability Eligible Dependent Insurance, unless such insurance is replaced by similar insurance under another group insurance policy issued to the Policyholder or its successor; or
    - this Policy has ended, unless such insurance is replaced by similar insurance under another group insurance policy issued to the Policyholder or its successor.

2. You may choose to Port the reduced amount of insurance if Your Portability Eligible Insurance is reduced due to:
   - Your age; or
   - an amendment to the Plan which affects the amount of insurance for Your class.
3. Your former Dependent Spouse may choose to Port if their Portability Eligible Dependent Insurance on his or her own life ends because:
   - You die; or
   - Your marriage ends in divorce or annulment

   provided that former Dependent Spouse satisfies the Additional Requirement subsection of the ELIGIBILITY PROVISIONS; INSURANCE FOR YOUR DEPENDENTS.
4. Your former Dependent Spouse may also Port Portability Eligible Dependent Insurance on Your Dependent Child if Your former Dependent Spouse Ports insurance on his or her own life. If Your former Dependent Spouse Ports that insurance on that Dependent Child, that Porting will have no effect on the insurance You may have on that Dependent Child.
5. Your former Dependent Child may request to Port Portability Eligible Dependent Insurance on his or her own life if that insurance ends because Your former Dependent Child no longer meets the definition of Child.

If a request is made under this subsection, We will issue a new certificate of insurance which will explain the new insurance benefits. The insurance benefits under the new certificate may not be the same as those that ended under this Policy.

A request under this subsection may be made, if on the date the Portability Eligible Insurance or Portability Eligible Dependent Insurance ended, the following requirements are met:

- the Group Policy is in effect;
- with respect to any amount of Portability Eligible Life Insurance or Portability Eligible Dependent Life Insurance that is to be Ported, no application has been made to convert that amount of insurance to an individual policy of life insurance as provided in the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU or the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS; and
- the person making the request resides in a jurisdiction that permits this Portability feature.

Request Period

For You or a former Dependent to Port, We must receive a completed request form within the Request Period as described below.

If written notice of the option to Port is given within 15 days before or after the date such insurance ends, the Request Period:

- begins on the date the insurance ends, and
- expires 31 days after the date.

If written notice of the option to Port is given more than 15 days after but within 91 days of the date such insurance ends, the Request Period:

- begins on the date the insurance ends, and
- expires 45 days after the date of the notice.

If written notice of the option to Port is not given within 91 days of the date such insurance ends, the Request Period:

- begins on the date the insurance ends, and
- expires at the end of such 91 day period.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (For MN Residents see Minnesota Notice Page) (continued)

Amount of the New Certificate

The amount of Ported Insurance for You and for Your Dependents that may be continued is shown in the SCHEDULE OF BENEFITS. However, at the time of Porting You may change the amount of Portability Eligible Insurance in the following circumstances:

Your Increase in Amount

For Portability Eligible Life Insurance

At the time of Porting, You may increase the amount of Your Portability Eligible Life Insurance. This may be done in increments of $25,000, up to a maximum ported amount of $2,000,000. To be eligible for this increased amount, You must provide evidence of Your insurability satisfactory to us, at Your expense. If We approve the increase, it will take effect on the date We state in Writing.

Dependent Spouse Increase in Amount

For Portability Eligible Dependent Life Insurance

At the time of Porting, the amount of Your Spouse's (or Your former Dependent Spouse's) Portability Eligible Dependent Life Insurance may be increased. This may be done in increments of $25,000, up to a maximum ported amount of $250,000. To be eligible for this increased amount, Your Spouse (or Your former Dependent Spouse) must provide evidence of insurability satisfactory to us, at Your Spouse's (or Your former Dependent Spouse's) expense. If We approve the increase, it will take effect on the date We state in Writing.

Dependent Child Increase in Amount

For Portability Eligible Dependent Life Insurance

At the time of Porting, if Your former Dependent Child is making the request to continue Portability Eligible Dependent Life Insurance because he or she no longer meets the definition of a Child, that former Dependent Child is eligible to increase coverage by $25,000. To be eligible for this increased amount, Your former Dependent Child must give evidence of insurability satisfactory to Us at Your former Dependent Child's expense. If we approve the increase, it will take effect on the date We state in Writing.

You and/or Your Dependent(s) Decrease in Amount

If We receive a request to decrease an amount of insurance, any such decrease will take place on the date We state in Writing.

Premiums for the New Certificate

All premium payments must be made directly to Us. When We issue the new certificate, We will also provide a schedule of premiums and payment instructions.

You are not required to provide evidence of insurability to Port Your existing amount of Portability Eligible Life Insurance. However, to qualify for a lower premium rate, You may give us, at Your expense, evidence of Your insurability satisfactory to Us. If We determine that the evidence satisfies Us, We will notify You that the lower premium rates will apply to You.

Your former Dependents are not required to provide evidence of insurability to Port their existing amount of Portability Eligible Dependent Life Insurance. However, to qualify for a lower premium rate, they may give us, at their expense, evidence of their insurability satisfactory to Us. If We determine that the evidence satisfies Us, We will notify them that the lower premium rates will apply to them.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (For MN Residents see Minnesota Notice Page) (continued)

Right to Convert Life Insurance Amounts Not Ported

Any amount of Life Insurance not Ported under this subsection may be converted under the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU or the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS.

If You Die Within 31 Days of the Date Portability Eligible Life Insurance Ends

If You die within 31 days of the date Portability Eligible Life Insurance ends and an application to Port is not received by Us during such period, We will determine whether Your life insurance qualifies for payment. This determination will be made in accordance with the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU.

If a former Dependent Dies Within 31 Days of the Date Portability Eligible Life Dependent Insurance Ends

If a former Dependent dies within 31 days of the date Portability Eligible Dependent Life Insurance ends and an application for a new certificate is not received by Us during such period, We will determine whether Your life insurance qualifies for payment. This determination will be made in accordance with the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS.

If You are Totally Disabled on the Date Your Employment Ends

If You are Totally Disabled on the date Your employment ends and You elect to Port as provided in this subsection, You may at a later date become approved for the continuation of insurance under the section entitled ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED. If You are so approved, all Ported insurance continued under this Portability subsection will end, including Life Insurance and Dependent Life Insurance.

AT THE POLICYHOLDER'S OPTION

The Policyholder has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below;

1. if You cease Active Work due to injury or sickness, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
2. if You cease Active Work due to layoff, for a period in accordance with the Policyholder's general practice for an employee in Your job class; or
3. if You cease Active Work due to any other Policyholder approved leave of absence, for a period in accordance with the Policyholder's general practice for an employee in Your job class.

The Policyholder's general practice for employees in a job class determines which employees with the above types of absences are to be considered as still insured and for how long among persons in like situations.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

If Your insurance ends, Your Dependents' insurance will also end in accordance with the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS.

EVIDENCE OF INSURABILITY

We require evidence of insurability satisfactory to Us as follows:

1. in order to become covered for an amount of Supplemental Life Insurance greater than the Non-Medical Issue Amount as shown in the SCHEDULE OF BENEFITS.

   If You do not give Us evidence of Your insurability, or if such evidence of insurability is not accepted by Us as satisfactory, the amount of Your Supplemental Life Insurance will be limited to the Non-Medical Issue Amount.

2. if You make a late request due to a Qualifying Event for Supplemental Life Insurance. A late request is one made more than 31 days after You become eligible.

   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Supplemental Life Insurance will not be more than the second level of coverage.

3. if You make a late request during an annual enrollment period for Supplemental Life Insurance. A late request is one made more than 31 days after You become eligible.

   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Supplemental Life Insurance will not be more than the second level of coverage.

4. if You make a request due to a Qualifying Event to increase the amount of Your Supplemental Life Insurance by more than two levels above Your current amount of Supplemental Life Insurance.

   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Supplemental Life Insurance if it is below the Non-Medical Issue Amount will be increased by two levels but not to exceed the Non-Medical Issue Amount.

5. if You make a request during an annual enrollment period to increase the amount of Your Supplemental Life Insurance by more than two levels above Your current amount of Supplemental Life Insurance.

   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Supplemental Life Insurance if it is below the Non-Medical Issue Amount will be increased by two levels but not to exceed the Non-Medical Issue Amount.

6. if You make a request during a Qualifying Event to increase the amount of Your Supplemental Life Insurance which is above the Non-Medical Issue Amount to a greater amount.

   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Supplemental Life Insurance will not be increased.

7. if You make a request during an annual enrollment period to increase the amount of Your Supplemental Life Insurance which is above the Non-Medical Issue Amount to a greater amount.

   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Supplemental Life Insurance will not be increased.

8. if You make a request during a Qualifying Event to increase the amount of Your Supplemental Life Insurance which is at or below the Non-Medical Issue Amount to an option level above the Non-Medical Issue Amount.

   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Supplemental Life Insurance will be increased by two levels but not to exceed the Non-Medical Issue Amount.

9. if You make a request during an annual enrollment period to increase the amount of Your Supplemental Life Insurance which is at or below the Non-Medical Issue Amount to an option level above the Non-Medical Issue Amount.

   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Supplemental Life Insurance will be increased by two levels but not to exceed the Non-Medical Issue Amount.

EVIDENCE OF INSURABILITY (continued)

10. in order to become covered for an amount of Life Insurance for Your Dependent Spouse greater than the Non-Medical Issue Amount for Your Dependent Spouse as shown in the SCHEDULE OF BENEFITS.

    If You do not give Us evidence of the insurability of Your Dependent Spouse, or if such evidence of insurability is not accepted by Us as satisfactory, the amount of Life Insurance for Your Dependent Spouse will be limited to the Non-Medical Issue Amount for Your Dependent Spouse.

11. if You make a late request due to a Qualifying Event for Life Insurance for Your Dependent Spouse. A late request is one made more than 31 days after You become eligible for Life Insurance for Your Dependent Spouse.

    If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Dependent Spouse Life Insurance will not be more than the second level of coverage.

12. if You make a late request during an annual enrollment period for Life Insurance for Your Dependent Spouse. A late request is one made more than 31 days after You become eligible for Life Insurance for Your Dependent Spouse.

    If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Dependent Spouse Life Insurance will not be more than the second level of coverage.

13. if You make a request due to a Qualifying Event to increase the amount of Life Insurance for Your Dependent Spouse by more than two levels above Your Dependent Spouse’s current amount of Life Insurance.

    If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Dependent Spouse’s Life Insurance if it is below the Non-Medical Issue Amount will be increased by two levels but not to exceed the Non-Medical Issue Amount.

14. if You make a request during an annual enrollment period to increase the amount of Life Insurance for Your Dependent Spouse by more than two levels above Your Dependent Spouse's current amount of Life Insurance.

    If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Dependent Spouse's Life Insurance if it is below the Non-Medical Issue Amount will be increased by two levels but not to exceed the Non-Medical Issue Amount.

15. if You make a request during a Qualifying Event to increase the amount of Life Insurance for Your Dependent Spouse which is above the Non-Medical Issue Amount to a greater amount.

    If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Dependent Spouse’s Life Insurance will not be increased.

16. if You make a request during an annual enrollment period to increase the amount of Life Insurance for Your Dependent Spouse which is above the Non-Medical Issue Amount to a greater amount.

    If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Dependent Spouse’s Life Insurance will not be increased.

17. if You make a request during a Qualifying Event to increase the amount of Life Insurance for Your Dependent Spouse which is at or below the Non-Medical Issue Amount to an option level above the Non-Medical Issue Amount.

    If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Dependent Spouse’s Life Insurance will be increased by two levels but not to exceed the Non-Medical Issue Amount.

18. if You make a request during an annual enrollment period to increase the amount of Life Insurance for Your Dependent Spouse which is at or below the Non-Medical Issue Amount to an option level above the Non-Medical Issue Amount.

    If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Dependent Spouse’s Life Insurance will be increased by two levels but not to exceed the Non-Medical Issue Amount.

The evidence of insurability is to be given at Your expense.

LIFE INSURANCE: FOR YOU

If You die, Proof of Your death must be sent to Us. When We receive such Proof with the claim, We will review the claim and, if We approve it, will pay the Beneficiary the Life Insurance in effect on the date of Your death.

PAYMENT OPTIONS

We will pay the Life Insurance in one sum. Other modes of payment may be available upon request. For details, call Our toll free number shown on the Certificate Face Page.

LIFE INSURANCE: FOR YOUR DEPENDENTS

If a Dependent dies, Proof of the Dependent's death must be sent to Us. When We receive such Proof with the claim, We will review the claim and, if We approve it, will pay the Beneficiary the Life Insurance in effect on the life of such Dependent on the date of death.

PAYMENT OPTIONS

We will pay the Life Insurance in one sum. Other modes of payment may be available upon request. For details, call Our toll free number shown on the Certificate Face Page.

LIFE INSURANCE: ACCELERATED BENEFIT OPTION (ABO) FOR YOU

For purposes of this section, the term "ABO Eligible Life Insurance" refers to each of Your Life Insurance benefits for which the Accelerated Benefit Option is shown as available in the SCHEDULE OF BENEFITS.

If You become Terminally Ill, You or Your legal representative have the option to request Us to pay ABO Eligible Life Insurance before Your death. This is called an accelerated benefit. The request must be made while ABO Eligible Life Insurance is in effect.

Terminally Ill or **Terminal Illness** means that due to injury or sickness, You are expected to die within 24 months.

Requirements For Payment of an Accelerated Benefit

Subject to the conditions and requirements of this section, We will pay an accelerated benefit to You or Your legal representative if:

- the amount of each ABO Eligible Life Insurance benefit to be accelerated equals or exceeds $4,500; and
- the ABO Eligible Life Insurance to be accelerated has not been assigned; and
- We have received Proof that You are Terminally Ill.

We will only pay an accelerated benefit for each ABO Eligible Life Insurance benefit once.

Proof of Your Terminal Illness

We will require the following Proof of Your Terminal Illness:

- a completed accelerated benefit claim form;
- a signed Physician's certification that You are Terminally Ill; and
- an examination by a Physician of Our choice, at Our expense, if We request it. If there is a conflicting opinion between Your Physician and Our Physician, we reserve the right to have a third Physician of Our choice make the determination.

You or Your legal representative should contact the Policyholder to obtain a claim form and information regarding the accelerated benefit.

Upon Our receipt of Your request to accelerate benefits, We will send You a letter with information about the accelerated benefit payment You requested. Our letter will describe the amount of the accelerated benefits We will pay and the amount of Life Insurance remaining after the accelerated benefit is paid.

Financing for the Accelerated Benefit Option

The cost of the Accelerated Benefit Option is part of the premium paid for Group Life Insurance under the plan. No more than 1.5% of the premium for Group Life Insurance is attributable to the financing of the Accelerated Benefit Option.

Accelerated Benefit Amount

We will pay an accelerated benefit up to the percentage shown in the SCHEDULE OF BENEFITS for each ABO Eligible Life Insurance benefit in effect for You, subject to the following:

Maximum Accelerated Benefit Amount. The maximum amount We will pay for each ABO Eligible Life Insurance benefit is shown in the SCHEDULE OF BENEFITS.

Scheduled Reduction of an ABO Eligible Life Insurance Benefit. If an ABO Eligible Life Insurance benefit is scheduled to reduce within the 24 month period after the date You or Your legal representative request an accelerated benefit, We will calculate the accelerated benefit using the amount of such ABO Eligible Life Insurance that will be in effect immediately after the reduction(s) scheduled for such period.

Scheduled End of an ABO Eligible Life Insurance Benefit. If an ABO Eligible Life Insurance benefit is scheduled to end within 24 months after the date You or Your legal representative request an accelerated benefit, We will not pay an accelerated benefit for such ABO Eligible Life Insurance benefit.

Previous Conversion of an ABO Eligible Life Insurance Benefit. We will not pay an accelerated benefit for any amount of ABO Eligible Life Insurance which You previously converted under the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU.

We will pay the accelerated benefit in one sum unless You or Your legal representative select another payment mode.

Effect of Payment of an Accelerated Benefit

On Contribution for Your Life Insurance. After We pay the accelerated benefit, any future contributions for Life Insurance You are required to pay will be waived.

On Your Life Insurance at Your death. We will pay the amount of Life Insurance in effect at Your death reduced by the amount of the accelerated benefit paid by Us.

Such payment shall constitute full settlement of Your Life Insurance under the Group Policy.

On Your Life Insurance at conversion. The amount to which You are entitled to convert under the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU will be decreased by the amount of the accelerated benefit paid by Us.

On Your Accidental Death and Dismemberment Insurance. Payment of an accelerated benefit will not affect Your Accidental Death and Dismemberment Insurance.

Date Your Option to Accelerate Benefits Ends

The accelerated benefit option will end on the earliest of:

- the date the ABO Eligible Life Insurance ends;
- the date You or Your legal representative assign all ABO Eligible Life Insurance; or
- the date You or Your legal representative have accelerated all ABO Eligible Life Insurance benefits.

LIFE INSURANCE: ACCELERATED BENEFIT OPTION (ABO) FOR YOUR SPOUSE

If Your Spouse becomes Terminally Ill, You or Your legal representative have the option to request Us to pay Life Insurance for Your Spouse before Your Spouse's death. This is called an accelerated benefit. The request must be made while Life Insurance for Your Spouse is in effect.

Terminally Ill or **Terminal Illness** means that due to injury or sickness, Your Spouse is expected to die within 24 months.

Requirements For Payment of an Accelerated Benefit

Subject to the conditions and requirements of this section, We will pay an accelerated benefit to You or Your legal representative if:

- the amount of Life Insurance for the Terminally Ill Spouse equals or exceeds $2,250;
- the ABO Eligible Life Insurance to be accelerated has not been assigned; and
- We have received Proof that Your Spouse is Terminally Ill.

We will only pay an accelerated benefit for Life Insurance for Your Spouse once.

Proof of Your Spouse's Terminal Illness

We will require the following Proof of Your Spouse's Terminal Illness:

- a completed accelerated benefit claim form;
- a signed Physician's certification that Your Spouse is Terminally Ill; and
- an examination by a Physician of Our choice, at Our expense, if We request it. If there is a conflicting opinion between Your Spouse's Physician and Our Physician, we reserve the right to have a third Physician of Our choice make the determination.

You or Your legal representative should contact the Policyholder to obtain a claim form and information regarding the accelerated benefit.

Upon Our receipt of Your request to accelerate benefits, We will send You a letter with information about the accelerated benefit payment You requested. Our letter will describe the amount of the accelerated benefits We will pay and the amount of Life Insurance remaining after the accelerated benefit is paid.

Financing for the Accelerated Benefit Option

The cost of the Accelerated Benefit Option is part of the premium paid for Group Life Insurance under the plan. No more than 1.5% of the premium for Group Life Insurance is attributable to the financing of the Accelerated Benefit Option.

Accelerated Benefit Amount

We will pay an accelerated benefit up to the percentage shown in the SCHEDULE OF BENEFITS for the amount of Life Insurance in effect for a Terminally Ill Spouse, subject to the following:

Maximum accelerated benefit amount. The maximum amount We will pay is shown in the SCHEDULE OF BENEFITS.

Scheduled reduction of Life Insurance for a Terminally Ill Spouse. If the Life Insurance in effect for a Terminally Ill Spouse is scheduled to reduce within the 24 month period after the date You or Your legal representative request an accelerated benefit, We will calculate the accelerated benefit using the amount of Life Insurance that will be in effect for Your Spouse immediately after the reduction(s) scheduled for such period.

LIFE INSURANCE: ACCELERATED BENEFIT OPTION (ABO) FOR YOUR SPOUSE (continued)

Scheduled end of Life Insurance for a Terminally Ill Spouse. If the Life Insurance in effect for a Terminally Ill Spouse is scheduled to end within 24 months after the date You or Your legal representative request an accelerated benefit, We will not pay an accelerated benefit.

We will pay the accelerated benefit in one sum unless You or Your legal representative select another payment mode.

Effect of Payment of an Accelerated Benefit

On Contribution for Life Insurance. After We pay the accelerated benefit, any future contributions for Life Insurance You are required to pay for Life Insurance for Your Spouse will be waived.

On Payment of Life Insurance at a Dependent's death. Upon the death of a Dependent for whom We paid an accelerated benefit, we will pay the amount of Life Insurance in effect on the life of such Dependent reduced by the amount of the accelerated benefit paid by Us for such Dependent.

Such payment shall constitute full settlement of the Life Insurance on the life of the Dependent under the Group Policy.

On Life Insurance at conversion. The amount to which Your Spouse for whom We paid an accelerated benefit is entitled to convert under the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS provision will be decreased by the amount of the accelerated benefit paid by Us for Your Spouse.

Date Your Option to Accelerate Benefits Ends

The accelerated benefit option for Your Spouse will end on the earliest of:

- the date Life Insurance for Your Spouse ends;
- the date Your rights in Life Insurance for Your Spouse are assigned; or
- the date You or Your legal representative have accelerated all Dependent Life Insurance benefits.

LIFE INSURANCE: CONVERSION OPTION FOR YOU

If Your life insurance ends or is reduced for any of the reasons stated below, You have the option to buy an individual policy of life insurance ("new policy") from Us during the Application Period in accordance with the conditions and requirements of this section. This is referred to as the "option to convert". Evidence of Your insurability will not be required.

When You Will Have the Option to Convert

You will have the option to convert when:

A. Your life insurance ends because:
   - You cease to be in an eligible class;
   - Your employment ends;
   - this Group Policy ends, provided You have been insured for life insurance for at least 5 continuous years; or
   - this Group Policy is amended to end all life insurance for an eligible class of which You are a member, provided You have been insured for at least 5 continuous years; or

B. Your life insurance is reduced:
   - on or after the date You attain age 60;
   - because You change from one eligible class to another; or
   - due to an amendment of this Group Policy.

If You opt not to convert a reduction in the amount of Your life insurance as described above, You will not have the option to convert that amount at a later date.

A reduction in the amount of Your life insurance as a result of the payment of an accelerated benefit will not give rise to a right to convert under this section.

Application Period

If You opt to convert Your Life Insurance for any of the reasons stated above, We must receive a completed conversion application form from You within 31 days after the date Your Life Insurance ends or is reduced.

Option Conditions

The option to convert is subject to the following:

A. Our receipt within the Application Period of:
   - Your Written application for the new policy; and
   - the premium due for such new policy;

B. the premium rates for the new policy will be based on:
   - Our rates then in use;
   - the form and amount of insurance for which you apply;
   - Your class of risk; and
   - Your age;

C. the new policy may be on any form then customarily offered by Us excluding term insurance;

D. the new policy will be issued without an accidental death and dismemberment benefit, an accelerated benefit option, a waiver of premium benefit or any other rider or additional benefit; and

E. the new policy will take effect on the 32nd day after the date Your life insurance ends or is reduced; this will be the case regardless of the duration of the Application Period.

LIFE INSURANCE: CONVERSION OPTION FOR YOU (continued)

Maximum Amount of the New Policy

If Your Life Insurance ends due to the end of this Group Policy or the amendment of this Group Policy to end all life insurance for an eligible class of which You are a member, the maximum amount of insurance that You may elect for the new policy is the lesser of:

- the amount of Your life insurance that ends under this Group Policy less the amount of life insurance for which You become eligible under any group policy within 31 days after the date insurance ends under this Group Policy; or
- $10,000.

If Your life insurance ends or is reduced due to the Policyholder's organizational restructuring, the maximum amount of insurance that You may elect for the new policy is the amount of Your life insurance that ends under this Group Policy less the amount of life insurance for which You become eligible under any other group policy within 31 days after the date insurance ends under this Group Policy.

If Your life insurance ends or is reduced for any other reason, the maximum amount of insurance that You may elect for the new policy is the amount of Your life insurance which ends under this Group Policy.

ADDITIONAL PROVISIONS IF YOU DIE OR BECOME DISABLED UNDER CERTAIN CONDITIONS

If You Die Within 31 Days After Your Life Insurance Ends Or Is Reduced

If You die within 31 days after Your life insurance ends or is reduced by an amount You are entitled to convert, Proof of Your death must be sent to Us. When We receive such Proof with the claim, We will review the claim and if We approve it will pay the Beneficiary. The amount We will pay is the amount You were entitled to convert.

The amount You were entitled to convert will not be paid as insurance under both a new individual conversion policy and the Group Policy.

If You Become Eligible To Have Insurance Continued Due To Your Total Disability

If You obtain a new individual conversion policy because Your life insurance ends or is reduced and You later become eligible to have insurance continued under the section entitled ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED, We will only continue Your life insurance under such section if the conversion policy is returned to Us.

If the conversion policy is returned to Us, We will refund the premium paid for such policy without interest, less any debt incurred under such policy.

We will not pay a benefit for insurance under both the Group Policy and the new individual conversion policy.

LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS

If life insurance for a Dependent ends or is reduced for any of the reasons stated below, You or that Dependent will have the option to buy from Us an individual policy of life insurance on the life of the Dependent ("new policy") during the Application Period in accordance with the conditions and requirements of this section. This is referred to as "the option to convert". Evidence of the Dependent's insurability will not be required.

When You or a Dependent Will Have the Option to Convert

You will have the option to convert life insurance for a Dependent when:

A. life insurance for the Dependent ends because:
   - You cease to be in an eligible class;
   - Your employment ends;
   - this Group Policy ends, provided You have been insured for life insurance for the Dependent for at least 5 continuous years; or
   - this Group Policy is amended to end all life insurance for Dependents for an eligible class of which You are a member, provided You have been insured for life insurance for the Dependent for at least 5 continuous years; or

B. life insurance for the Dependent is reduced:
   - on or after the date You attain age 60;
   - because You change from one eligible class to another; or
   - due to an amendment of this Group Policy.

A Dependent will have the option to convert when:

- life insurance for such Dependent ends because that Dependent ceases to qualify as a Dependent as defined in this certificate, or
- You die.

If You opt not to convert a reduction in the amount of life insurance for a Dependent, You will not have the option to convert that amount at a later date.
A reduction in the amount of life insurance for a Dependent as a result of the payment of an accelerated benefit will not give rise to a right to convert under this section.

You must notify the Policyholder in the event that a Dependent ceases to qualify as a Dependent as defined in this certificate.

Application Period

If You or a Dependent opt to convert as stated above, We must receive a completed conversion application form within 31 days of the date Life Insurance for the Dependent ends or is reduced.

Option Conditions

The option to convert is subject to the following:

A. Our receipt within the Application Period of:
   - a Written application for the new policy for the Dependent; and
   - the premium due for such new policy;

B. the premium rates for the new policy will be based on:
   - Our rates then in use;
   - the form and amount of insurance which is applied for;
   - the Dependent's class of risk; and
   - the Dependent's age;

C. the new policy may be on any form then customarily offered by Us excluding term insurance;

D. the new policy will be issued without an accidental death and dismemberment benefit, an accelerated benefit option, waiver of premium benefit or any other rider or additional benefit; and

E. the new policy will take effect on the 32nd day after the date Life Insurance for the Dependent ends or is reduced; this will be the case regardless of the duration of the Application Period.

Maximum Amount of the New Policy

If Life Insurance for a Dependent ends due to the end of this Group Policy or the amendment of this Group Policy to end all life insurance for Dependents for an eligible class of which You are a member, the maximum amount of insurance that may be elected for the new policy is the lesser of:

- the amount of Life Insurance for the Dependent that ends under this Group Policy less the amount of life insurance for Dependents for which You become eligible under any group policy within 31 days after the date insurance ends under this Group Policy; or
- $10,000.

If life insurance for a Dependent ends or is reduced due to the Policyholder's organizational restructuring, the maximum amount of insurance that may be elected for the new policy is the amount of life insurance for the Dependent that ends under this Group Policy less the amount of life insurance for dependents for which You become eligible under any other group policy within 31 days after the date insurance ends under this Group Policy.

If Your life insurance for a Dependent ends or is reduced for any other reason, the maximum amount of insurance that You may elect for the new policy is the amount of Your life insurance for a Dependent that ends under this Group Policy.

ADDITIONAL PROVISIONS IF A DEPENDENT DIES

If a Dependent Dies Within the 31 Days After Life Insurance for a Dependent Ends Or Is Reduced

If a Dependent dies within 31 days after the date life insurance for the Dependent ends or is reduced by an amount eligible for convert, Proof of the Dependent's death must be sent to Us. When we receive such Proof with the claim, We will review the claim and if We approve it, will pay the Beneficiary. The amount We will pay is the amount that could have been converted.

The amount that could have been converted will not be paid as insurance under both a new individual conversion policy and the Group Policy.

ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED

If You become Totally Disabled while You are insured for Continuation Eligible Insurance under this policy, You may qualify to continue certain insurance under this section. If continued, premium payment will not be required. We will determine if You qualify for this continuation after We receive Proof that You have satisfied the conditions of this section.

Total Disability must start before You attain age 60 and while You are insured for Continuation Eligible Insurance.

Your Total Disability must continue without interruption from the date You became Totally Disabled through the end of the Continuation Waiting Period, except as follows. If You return to Active Work after completing part or all of the Continuation Waiting Period and later cease Active Work due to the same or a related Total Disability while Your Continuation Eligible Insurance is still in effect, You will be given credit for the prior partial or total completion of the Continuation Waiting Period and it will be considered a continuation of the original Total Disability. For example, if You complete the Continuation Waiting Period in the original period of Total Disability, You will not need to complete another Continuation Waiting Period. You must notify Us of the later period of Total Disability within 12 months of when that period began. The amount of insurance being continued will be the same as during the original period of Total Disability, subject to any reductions in coverage amount due to age. However, if (a) You increase Your Continuation Eligible Insurance after returning to Active Work and as part of the process provide evidence of insurability which satisfies Us, or (b) the amount of Continuation Eligible Insurance increases due to a change in Your earnings, that increase will be taken into account in determining the amount of insurance being continued.

DEFINITIONS

For the purpose of this section, “Continuation Eligible Insurance” means

- Basic Life Insurance, if You were insured for Basic Life Insurance for 12 months before Total Disability began; and
- Supplemental Life Insurance, if You were insured for Supplemental Life Insurance for 12 months before Total Disability began;

to the extent that such insurance was in effect for You on the date Your Total Disability began.

Continuation Eligible Insurance does not include:

- Life Insurance amounts accelerated under the section entitled LIFE INSURANCE: ACCELERATED BENEFIT OPTION FOR YOU.

Continuation Waiting Period means the period which starts on the date You become Totally Disabled and ends 6 consecutive months later.

Total Disability or **Totally Disabled** means, for purposes of this section, that due to an injury or Sickness:

- You are unable to perform the material duties of Your regular job; and
- You are unable to perform any other job for which You are fit by education, training or experience.

TOTAL DISABILITY AND PROOF REQUIREMENTS

If You become disabled You should contact Us as soon as reasonably possible. After the Continuation Waiting Period ends, You must send Us Proof that You were Totally Disabled throughout the Continuation Waiting Period. You must do this within the time frame specified in the section entitled FILING A CLAIM.

As part of such Proof, We may choose a Physician to examine You to verify that You are Totally Disabled. We will pay for the exam.

After We receive and review Your Proof, We will determine if You qualify. We will notify You in writing of Our decision.

ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED (continued)

To verify that You continue to be Totally Disabled, We may require from time to time that You send Us Proof that You continue to be Totally Disabled. We will not ask for Proof more than once each year.

IF YOU DIE DURING CONTINUATION

If You die during the continuation, Proof of the death must be sent to Us. In addition to the Proof which is otherwise required for the insurance, the Proof must show that Your Total Disability continued from the date We informed You that the continuation was approved until the date of the death.

When We receive such Proof with the claim, We will review the claim and if We approve it, will pay any benefit payable under the insurance continued under this section.

EFFECT OF PREVIOUS CONVERSION

If You converted any portion of Your Continuation Eligible Life Insurance to an individual policy, We will only pay the life insurance under this section if the individual policy is returned to Us. If it is returned to Us, We will refund to Your estate the premiums paid for such policy without interest, less any debt incurred under such policy.

If such individual policy is not returned to Us, We will pay the life insurance in effect under the individual policy.

We will not pay insurance under both the Group Policy and the individual policy.

EFFECT OF PREVIOUS ELECTION TO PORT COVERAGE

If You ported any portion of Your Continuation Eligible Insurance to a certificate under another policy, We will only pay insurance under this section if the other policy's certificate is surrendered to Us. If it is returned to Us, We will refund to Your estate the premiums paid under such policy without interest.

If that certificate is not returned to Us, We will pay any insurance which applies under the other policy's certificate.

We will not pay insurance under both this Group Policy and the other policy.

DATE CONTINUATION ENDS

The Continuation Eligible Insurance continued under this section may be continued in a reduced amount on account of the payment of accelerated benefits and will end at the earliest of:

1. the date You die;
2. the date Your Total Disability ends;
3. the date You do not give Us Proof of Total Disability, as required;
4. the date You refuse to be examined by Our Physician, as required;
5. the date You attain age 70.

Option To Convert Your Continuation Eligible Life Insurance

When a continuation under this section ends, You may buy an individual policy of life insurance from Us. The details of this option are described in the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU. For the purpose of that section, the end of this continuation will be considered the end of Your employment. You may not use the conversion option described in those sections if before the end of the Application Period for conversion You return to Active Work in an eligible class and become insured under the Group Policy. You will not be able to convert any of Your Continuation Eligible Life Insurance which You have already converted to an individual policy.

ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED (continued)

Option To Port Your Continuation Eligible Insurance

When a continuation under this section ends, You may elect to port to a different policy the insurance which has been continued under this section. The details of this option are described in the At Your Option: Portability subsection of the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT section. For the purpose of that section, the end of this continuation will be considered the end of Your employment. You may not use the portability option described in that section if before the end of the Portability Request Period, You return to Active Work in an eligible class and become insured under the Group Policy. You will not be able to port any of Your Continuation Eligible Insurance which You have already converted to an individual policy.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

If You sustain an accidental injury that is the Direct and Sole Cause of a Covered Loss described in the SCHEDULE OF BENEFITS, Proof of the accidental injury and Covered Loss must be sent to Us. When We receive such Proof We will review the claim. If We approve the claim, We will pay the insurance in effect on the date of the injury within 60 days of Our receipt of such proof.

Direct and Sole Cause means that the Covered Loss occurs within 12 months of the date of the accidental injury and was a direct result of the accidental injury, independent of other causes.

We will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

PRESUMPTION OF DEATH

You will be presumed to have died as a result of an accidental injury if:

- the aircraft or other vehicle in which You were traveling disappears, sinks, or is wrecked; and
- the body of the person who has disappeared is not found within 1 year of:
  - the date the aircraft or other vehicle was scheduled to have arrived at its destination, if traveling in an aircraft or other vehicle operated by a Common Carrier; or
  - the date the person is reported missing to the authorities, if traveling in any other aircraft or other vehicle.

EXCLUSIONS (See notice page for residents of Missouri)

We will not pay benefits under this section for any loss caused or contributed to by:

1. physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
2. infection, other than infection occurring in an external accidental wound or from food poisoning;
3. suicide or attempted suicide;
4. intentionally self-inflicted injury;
5. service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country;
6. any incident related to:
   - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
   - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
   - parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
   - travel in an aircraft or device used:
     - for testing or experimental purposes;
     - by or for any military authority; or
     - for travel or designed for travel beyond the earth’s atmosphere;
7. committing or attempting to commit a felony;

8. the voluntary intake or use by any means of:
    - any drug, medication or sedative, unless it is:
        - taken or used as prescribed by a Physician; or
        - an "over the counter" drug, medication or sedative taken as directed;
    - alcohol in combination with any drug, medication, or sedative; or
    - poison, gas, or fumes; or
9. war, whether declared or undeclared; or act of war, participation in an insurrection, rebellion or riot.

Exclusion for Intoxication

We will not pay benefits under this section for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

BENEFIT PAYMENT

For loss of Your life, We will pay benefits to Your Beneficiary.

For any other loss sustained by You We will pay benefits to You.

If You sustain more than one Covered Loss due to an accidental injury, the amount We will pay, on behalf of any such injured person, will not exceed the Full Amount.

We will pay benefits in one sum. Other modes of payment may be available upon request. For details call Our toll free number shown on the Certificate Face Page.

APPLICABILITY OF PROVISIONS

The provisions set forth in this ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section apply to all Accidental Death and Dismemberment Insurance – Additional Benefit sections included in this certificate except as may otherwise be provided in such Additional Benefit sections.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)

ADDITIONAL BENEFIT: SEAT BELT USE

If You die as a result of an accidental injury, We will pay this additional Seat Belt Use benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that the deceased person:
    - was in an accident while driving or riding as a passenger in a Passenger Car;
    - was wearing a Seat Belt which was properly fastened at the time of the accident; and
    - died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the Seat Belt was properly fastened. A copy of such certification must be submitted to Us with the claim for benefits.

Passenger Car means any validly registered four-wheel private passenger car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes, or any vehicle used for recreational or professional racing.

Seat Belt means any restraint device that:

- meets published United States Government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

The term includes any child restraint device that meets the requirements of state law.

BENEFIT AMOUNT

The Seat Belt Use Benefit is an additional benefit equal to 10% of the Full Amount shown in the SCHEDULE OF BENEFITS. However, the amount We will pay for this benefit will not be more than $25,000.

BENEFIT PAYMENT

For loss of Your life, We will pay benefits to Your Beneficiary.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)

ADDITIONAL BENEFIT: AIR BAG USE

If You die as a result of an accidental injury, We will pay this additional benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;

2. this benefit is in effect on the date of the injury; and

3. We receive Proof that the deceased person:

   - was in an accident while driving or riding as a passenger in a Passenger Car equipped with an Air Bag(s);
   - was riding in a seat protected by an Air Bag;
   - was wearing a Seat Belt which was properly fastened at the time of the accident; and
   - died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the Seat Belt was properly fastened and that the Passenger Car in which the deceased was traveling was equipped with Air Bags. A copy of such certification must be submitted to Us with the claim for benefits.

Passenger Car means any validly registered four-wheel private passenger car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes, or any vehicle used for recreational or professional racing.

Seat Belt means any restraint device that:

- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

The term includes any child restraint device that meets the requirements of state law.

Air Bag means an inflatable restraint device that:

- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

BENEFIT AMOUNT

The Air Bag Use Benefit is an additional benefit equal to 10% of the Full Amount shown in the SCHEDULE OF BENEFITS. However, the amount We will pay for this benefit will not more than $5,000.

BENEFIT PAYMENT

For loss of Your life, We will pay benefits to Your Beneficiary.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)

ADDITIONAL BENEFIT: CHILD CARE

If You die as a result of an accidental injury, We will pay this additional Child Care benefit if:

1. We pay a benefit for loss of Your life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that:
   - on the date of death a Child was enrolled in a Child Care Center; or
   - within 12 months after the date of death a Child was enrolled in a Child Care Center.

Child Care Center means a facility that:

- is operated and licensed according to the law of the jurisdiction where it is located; and
- provides care and supervision for children in a group setting on a regularly scheduled and daily basis.

BENEFIT AMOUNT

For each Child who qualifies for this benefit, We will pay an amount equal to the Child Care Center charges incurred for a period of up to 4 consecutive years, not to exceed:

- an annual maximum of $5,000; and
- an overall maximum of 12% of the Full Amount shown in the SCHEDULE OF BENEFITS.

We will not pay for Child Care Center charges incurred after the date a Child attains age 13.

We may require Proof of the Child's continued enrollment in a Child Care Center during the period for which a benefit is claimed.

BENEFIT PAYMENT

We will pay this benefit quarterly when We receive Proof that Child Care Center charges have been paid. Payment will be made to the person who pays such charges on behalf of the Child.

If this benefit is in effect on the date You die and there is no Child who could qualify for it, We will pay $1,000 to Your Beneficiary in one sum.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)

ADDITIONAL BENEFIT: CHILD EDUCATION

If You die as a result of an accidental injury, We will pay this additional Child Education benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that on the date of death a Child was:
    - enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level; or
    - at the 12th grade level and, within one year after the date of death, enrolls as a full-time student in an accredited college, university or vocational school.

BENEFIT AMOUNT

For each Child who qualifies for this benefit, We will pay an amount equal to the tuition charges incurred for a period of up to 4 consecutive academic years, not to exceed:

- an academic year maximum of $10,000; and
- an overall maximum of 20% of the Full Amount shown in the SCHEDULE OF BENEFITS.

We may require Proof of the Child's continued enrollment as a full-time student during the period for which a benefit is claimed.

BENEFIT PAYMENT

We will pay this benefit semi-annually when We receive Proof that tuition charges have been paid. Payment will be made to the person who pays such charges on behalf of the Child.

If this benefit is in effect on the date of death and there is no Child who could qualify for it, We will pay $1,000 to Your Beneficiary in one sum.

ADDITIONAL BENEFIT: SPOUSE EDUCATION

If You die as a result of an accidental injury, We will pay this additional Spouse Education benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that:
   - on the date of Your death, Your Spouse was enrolled in an accredited school; or
   - within 12 months after the date of Your death, Your Spouse enrolls in an accredited school.

BENEFIT AMOUNT

We will pay an amount equal to the tuition charges incurred for a period of up to 1 academic year, not to exceed:

- an academic year maximum of $5,000; and
- an overall maximum of 5% of the Full Amount shown in the SCHEDULE OF BENEFITS.

We may require Proof of the Spouse's continued enrollment during the period for which a benefit is claimed.

BENEFIT PAYMENT

We will pay this benefit semi-annually when We receive Proof that tuition charges have been paid. Payment will be made to the Spouse.

If this benefit is in effect on the date You die and there is no Spouse who could qualify for it, We will pay $1,000 to Your Beneficiary in one sum.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)

ADDITIONAL BENEFIT: HOSPITAL CONFINEMENT

Subject to the provisions of the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE, We will pay this additional benefit if:

1. We receive Proof that You are confined in a Hospital as a result of an accidental injury which is the direct cause of such confinement independent of other causes; and
2. this benefit is in effect on the date of the injury.

BENEFIT AMOUNT

We will pay an amount for each full month of Hospital Confinement equal to the lesser of:

- 1% of the Full Amount shown in the SCHEDULE OF BENEFITS; and
- $2,500.

We will pay this benefit on a monthly basis beginning on the 5th day of confinement, for up to 12 months of continuous confinement. This benefit will be paid on a pro-rata basis for any partial month of confinement.

We will only pay benefits for one period of continuous confinement for any accidental injury. That period will be the first period of confinement that qualifies for payment.

BENEFIT PAYMENT

Benefit payments will be made monthly. Payment will be made to You.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)

ADDITIONAL BENEFIT: COMMON CARRIER

If You die as a result of an accidental injury, We will pay this additional benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;

2. this benefit is in effect on the date of the injury; and

3. We receive Proof that the injury resulting in the deceased's death occurred while traveling in a Common Carrier.

BENEFIT AMOUNT

The Common Carrier Benefit is shown in the SCHEDULE OF BENEFITS.

BENEFIT PAYMENT

For loss of Your life, We will pay benefits to Your Beneficiary.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)

ADDITIONAL BENEFIT: REPATRIATION EXPENSE

If You die as a result of an accidental injury, We will pay this additional benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that Your death occurred at least 100 miles from Your principal place of residence.

BENEFIT AMOUNT

We will pay an additional benefit equal to the charges incurred for the preparation and transportation of the deceased's body to the city of the deceased's principal residence; not to exceed $5,000.

BENEFIT PAYMENT

We will pay this benefit when We receive Proof that the charges described above have been paid. Payment will be made to the person who paid such charges.

FILING A CLAIM

CLAIMS FOR LIFE INSURANCE BENEFITS

When there has been the death of an insured person, notify the Policyholder. This notice should be given to the Policyholder as soon as is reasonably possible after the death. The claim form will be sent to the beneficiary or beneficiaries of record.

The beneficiary or beneficiaries should complete the claim form and send it and Proof of the death to Us as instructed on the claim form.

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy. The benefit amount may be reduced by the amount of any due and unpaid contributions to premium outstanding at the time We make payment.

When a claimant files a claim to continue Life Insurance on account of Total Disability, notice and Proof should be sent to Us as soon as reasonably possible, but in any event must be received by Us within 12 months of the date the claimant became Totally Disabled, except in the case of legal incapacity of the claimant.

FILING A CLAIM

CLAIMS FOR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

When there has been a Covered Loss, notify the Policyholder. This notice should be given to the Policyholder as soon as is reasonably possible but in any case within 20 days of the Covered Loss. The claim form will be sent to You or the beneficiary or beneficiaries of record.

The claim form should be completed and sent along with Proof of the Covered Loss to Us as instructed on the claim form. If You or the beneficiary have not received a claim form within 15 days of giving notice of the claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

The claimant must give us Proof no later than 90 days after the date of the Covered Loss.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice or Proof are given as soon as is reasonably possible.

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy.

Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

GENERAL PROVISIONS

Assignment

You may assign Your Life Insurance rights and benefits under the Group Policy as a gift or as a viatical assignment. You may also assign Your Accidental Death and Dismemberment Insurance rights and benefits under the Group Policy as a gift. We will recognize the assignee(s) under such assignment as owner(s) of Your right, title and interest in the Group Policy if:

1. a Written form satisfactory to Us, affirming this assignment, has been completed;
2. the Written form has been Signed by You and the assignee(s);
3. the Policyholder acknowledges that Your Life Insurance and Accidental Death and Dismemberment Insurance being assigned is in force on the life of the assignor; and
4. the Written form is delivered to Us for recording.

We are not responsible for the validity of an assignment.

You may have made an irrevocable assignment under a group policy that the Group Policy replaces. In this case, We will recognize the assignee(s) under such assignment as owners of Your right, title and interest under the Group Policy if:

1. a Written form satisfactory to Us, affirming this assignment, has been completed;
2. the Written form has been Signed by You, the assignee(s) and the Policyholder; and
3. the Written form is delivered to Us for recording.

Beneficiary

You may designate a Beneficiary in Your application or enrollment form. You may change Your Beneficiary at any time. To do so, You must send a Signed and dated, Written request to the Policyholder using a form satisfactory to Us. Your Written request to change the Beneficiary must be sent to the Policyholder within 30 days of the date You Sign such request.

You do not need the Beneficiary's consent to make a change. When We receive the change, it will take effect as of the date You Signed it. The change will not apply to any payment made in good faith by Us before the change request was recorded.

If two or more Beneficiaries are designated and their shares are not specified, they will share the insurance equally.

If there is no Beneficiary designated or no surviving designated Beneficiary at Your death, We may determine the Beneficiary to be one or more of the following who survive You:

- Your Spouse;
- Your child(ren);
- Your parent(s); or
- Your sibling(s).

Instead of making payment to any of the above, We may pay Your estate. Any payment made in good faith will discharge our liability to the extent of such payment. If a Beneficiary or a payee is a minor or incompetent to receive payment, We will pay that person's guardian.

GENERAL PROVISIONS (continued)

For Your Life Insurance for Your Dependents, We will pay You as the Beneficiary if alive. If you are not alive, We may determine the Beneficiary to be one or more of the following who survive You:

- Your Spouse;
- Your child(ren);
- Your parent(s); or
- Your sibling(s).

Instead of making payment to any of the above, We may pay Your estate. Any payment made in good faith will discharge our liability to the extent of such payment.

If You and any Dependent die within a 24 hour period, We will pay the Dependent's Life Insurance to the Beneficiary receiving payment of your Life Insurance or We may pay Your estate. If a Beneficiary or a payee is a minor or incompetent to receive payment, We will pay that person's guardian.

Suicide(See notice page for residents of Missouri) (See notice page for residents of North Dakota) (See notice page for residents of Washington)

For Supplemental Life

If You commit suicide within 2 years from the date Life Insurance for You takes effect, We will not pay such insurance and Our liability will be limited as follows:

- any premium paid by You will be returned to the Beneficiary; and
- any premium paid by the Policyholder will be returned to the Policyholder.

If You commit suicide within 2 years from the date an increase in Your Life Insurance takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

For Dependent Life

If a Dependent commits suicide within 2 years from the date Life Insurance for such Dependent takes effect, We will not pay such insurance and Our liability will be limited as follows:

- any premium paid by You will be returned to the Beneficiary; and
- any premium paid by the Policyholder will be returned to the Policyholder.

If a Dependent commits suicide within 2 years from the date an increase in Life Insurance for such Dependent takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

Entire Contract

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

GENERAL PROVISIONS (continued)

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

For Life Insurance

We will not use Your statements which relate to insurability to contest insurance after it has been in force for 2 years during Your life. In addition, We will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during Your life.

For Accidental Death and Dismemberment Insurance

We will not use Your statements which relate to insurability to contest Accidental Death and Dismemberment Insurance after it has been in force for 2 years during Your life, unless the statement is fraudulent. In addition, We will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during Your life, unless the statement is fraudulent.

Misstatement of Age

If Your or Your Dependent's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

Conformity with Law

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

Physical Exams

If a claim is submitted for insurance benefits other than life insurance benefits, We have the right to ask the insured to be examined by a Physician(s) of Our choice as often as is reasonably necessary to process the claim. We will pay the cost of such exam.

Autopsy

We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

THE PRECEDING PAGE IS THE END OF THE CERTIFICATE.
THE FOLLOWING IS ADDITIONAL INFORMATION.

Delaware American Life Insurance Company
MetLife Health Plans, Inc.
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.
Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

1.Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

2.Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

3.Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a legal plans company, and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

4.How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901, or by contacting MIB at www.mib.com.

5.Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what

products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

6.Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our “Using Your Information” section above

7.HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act (“HIPAA”) protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

8.Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

9.Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE CLUBCORP USA, INC. TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

ERISA INFORMATION

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

ClubCorp USA, Inc.

3030 LBJ Freeway Suite 600

Dallas, TX 75234

972-888-7488

EMPLOYER IDENTIFICATION NUMBER: 75-2114856

PLAN NUMBER	COVERAGE	PLAN NAME
501	All Coverages	ClubCorp Health Benefits Plan, a Health and Welfare Benefit Plan

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

MetLife is liable for all life and accidental death and dismemberment insurance.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the rights to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event Your insurance ends in accordance with the DATE YOUR INSURANCE ENDS and DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsections of Your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife certificate.

CONTRIBUTIONS TO PREMIUM

If you enroll for Supplemental Life Insurance and Dependent Life Insurance coverage, you are required to make contributions to premiums.

If you enroll for certain contributory insurance, a portion of your contributions for such insurance will be allocated to reduce the Policyholder's cost of certain noncontributory insurance under the Policyholder's group insurance program

Premium rates are set by MetLife.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 1st and ending on the following December 31st.

CLAIMS INFORMATION

Procedures for Presenting Claims for Life and Accidental Death and Dismemberment Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions about the insurance benefits and to assist the claimant in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Claim Submission

In submitting claims for life and accidental death and dismemberment benefits ("Benefits"), the claimant must complete the appropriate claim form and submit the required Proof as described in the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After MetLife receives a claim for Benefits, MetLife will review the claim and notify the claimant of its decision to approve or deny the claim.

Such notification will be provided to the claimant within a reasonable period, not to exceed 90 days from the date we received the claim, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies the claim in whole or in part, the notification of the claims decision will state the reason why the claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of the claimant's right to bring a civil action if the claim is denied after an appeal.

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, the claimant can request a review of the claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after the claimant received notice of denial of the claim. When requesting a review, the claimant should state the reason the claimant believes the claim was improperly denied and submit in writing any written comments, documents, records or other information the claimant deems appropriate. Upon the claimant's written request, MetLife will provide the claimant free of charge with copies of relevant documents, records and other information.

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and the claimant will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received the request for review, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send the claimant a final written decision that states the reason(s) why the appealed claim is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of the claimant's right to bring a civil action if the claim is denied after an appeal. Upon written request, MetLife will provide the claimant free of charge with copies of documents, records and other information relevant to the claim.

Claims Involving Disability Determinations in connection with Life Insurance

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Claim Submission

For any claim which requires a determination of disability in connection with life insurance, the claimant must complete the appropriate claim form and submit the required proof as described in the certificate. For example, if your Plan provides that you are not required to continue paying for your life insurance coverage after you are found to be disabled, or if your plan provides that a portion of your life insurance benefits are payable to you after you are found to be disabled, your request for such determination is treated as a claim involving a disability determination.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After MetLife receives your claim involving a disability determination, your claim will be reviewed and you will be notified of the decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date we received your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife’s notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45-day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

FUTURE OF THE PLAN

It is hoped that This Plan will be continued indefinitely, but ClubCorp USA, Inc. reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of ClubCorp USA, Inc. shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.

Supplementary ERISA Information For Legal Services

The ERISA information set forth above which pertains to Group Supplemental Life Insurance also applies to Legal Services – Will Preparation Benefit and Estate Resolution Benefit, except as noted below:

Coverage

Legal Services – Will Preparation Benefit and Estate Resolution Benefit

Type of Administration

Legal Services – Will Preparation Benefit and Estate Resolution Benefit is administered by MetLife Legal Plans, Inc.

Agent for Service of Legal Process

For disputes arising under those portions of the Plan administered by MetLife Legal Plans, Inc., service of legal process may be made upon MetLife Legal Plans, Inc.

Eligibility For Will Preparation Benefit and Estate Resolution Benefit - Description or Summary of Benefits

Your MetLife Group Supplemental Life Insurance certificate describes the eligibility requirements for the Legal Services - Will Preparation Benefit and Estate Resolution Benefit under the Plan. It also includes a summary description of the benefit. For more detailed information, you may contact the provider, MetLife Legal Plans, Inc. by phone at 1-800-821-6400.

Plan Termination or Changes

The Will Preparation Benefit and Estate Resolution Benefit is being provided by MetLife Legal Plans, Inc. through an agreement between MetLife and MetLife Legal Plans, Inc. and may be terminated at any time.

Contributions

No contribution is required for Legal Services – Will Preparation Benefit and Estate Resolution Benefit.

Claims Information

Claims information for Legal Services – Will Preparation Benefit and Estate Resolution Benefit may be obtained by contacting the provider, MetLife Legal Plans, Inc. by phone at 1-800-821-6400.

For information about the Will Preparation Service and Estate Resolution Service, you may contact the provider, MetLife Legal Plans, Inc. by phone.

Phone: 1-800-821-6400

Pharmacy Benefits - OptumRx



Get smart about prescriptions

Our online tools make it easy

After **January 1, 2023**, you can access:

My prescriptions – See your current prescriptions along with information about how to use them and possible side effects.

Price a drug – Search your current or new medications to see costs at pharmacies near you. If you're taking a brand-name drug, you can also see prices for generic options.

View my claims – See which prescriptions you've filled and how much you paid.

Pharmacy locator – Search for network pharmacies near you – or find a pharmacy when you're traveling.

Getting started

Visit **optumrx.com** to register your account. You'll need information from your new member ID card to sign up. Then after **January 1**, 2023 access your account details and prescriptions.

To learn more now about Optum Rx and your drug plan, scan this code

Get the app. Download the Optum Rx app to manage your medications on the go.

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Online OE support includes https://welcome.optumrx.com/standard/getstarted and https://www.optumrx.com/oe_htctpremium/landing

MetLife | Legal Plans

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Legal help made easy

MetLife Legal Plans provides you, your spouse/domestic partner and dependents with access to a network of experienced attorneys. Having an attorney on your side can help reduce worry, stress, and financial burden when legal matters arise.

1 Easy to find an attorney

Visit **members.legalplans.com** to learn more about your plan. Search for an attorney based on your ZIP code and filters such as attorney experience, specialty, or minority, veteran, or LGBTQ-owned. Or call the Client Service Center to speak with an experienced representative that can match you with the right attorney.

2 Easy to make an appointment

Call the attorney directly after searching on our website. Meet with an attorney in person or over the phone. Or call the Client Service Center at **800-821-6400** and we will schedule your appointment directly with the attorney.

3 Easy from start to finish

That's it! There are no limits on the number of times you can use the benefit. And no copays, deductibles or claim forms when you use a network attorney for a covered matter.

Experience and convenience you can count on.

You'll have all the help you're looking for from our dedicated service team, network of attorneys and variety of online resources.



Award-winning service

- Regularly recognized for excellence in customer service[1]
- Experienced, Ohio-based service team available from 8:00 a.m. to 8:00 p.m., ET



Top-quality attorney network

- Nationwide network of attorneys with a range of specialties
- Average of 25 years of experience and vetted regularly



24/7 access at your fingertips

- Create an account on our website to access coverage information and our attorney locator
- Access to over 1,700 self-help documents and resources online
- Access to digital estate planning to create wills, living wills, and powers of attorney all online



Ease of use[2]

- All billing is handled between MetLife and the attorney
- No claim forms, hidden fees or deductibles

1. Two-time winner of the Silver Stevie in the American Business Awards, 2016 and 2017; Bronze winner in 2018, 2019 and 2020.
2. When using a network attorney for a covered legal matter.

Group legal plans are administered by MetLife Legal Plans, Inc., Cleveland, Ohio. In California, this entity operates under the name MetLife Legal Insurance Services. In certain states, group legal plans are provided through insurance coverage underwritten by Metropolitan General Insurance Company, Warwick, RI. For costs and complete details of the coverage, call or write the company. Some services not available in all states.

Navigating life together

MetLife Legal Plans, Inc. | 1111 Superior Avenue, Suite 800 | Cleveland, OH 44114

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MetLife | Legal Plans

Invited



MetLife Legal Plans offers you protection at every step

Your legal plan benefit is like having a trusted attorney in your pocket or on retainer. The attorney will advocate for your best interests and help you navigate legal issues. This may sound like a luxury, but it doesn't have to be! Our coverage provides access to a network of qualified and experienced attorneys nationwide. Plan benefits include:

- A cost-effective plan, at $9.25 per month, providing access to more than 18,000+ experienced network attorneys.[1]
- Unlimited use of network attorneys for covered issues.
- Assistance for a wide range of legal needs, including money matters, home and real estate, family and personal matters, civil lawsuits, elder care issues, and vehicles and driving.
- Online digital estate planning tool—create wills and trusts, healthcare proxies, and power of attorney documents from the comfort of home.

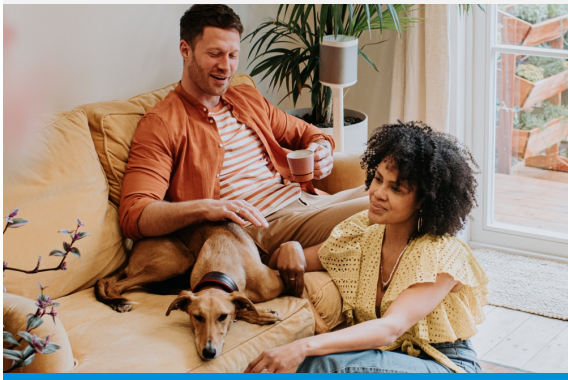
We've made finding legal help easy for you! Our network attorneys are available in person, by phone or by email.

We also offer online tools to complete **Estate Planning Documents** in as little as 15 minutes. You can also download self-help legal forms.

Not sure if a Legal Plan is right for you?

Get an idea of what and how we can make it easy to get the legal help you may need through your life. Scan the QR code or visit www.legalplans.com/whyenroll.

Scan to access: Why choose MetLife Legal Plans?



Ensure you have legal protection for what comes next

To enroll in these benefits, visit www.myclublifeonline.com

Legal Plans

Cover the costs of a wide range of common legal issues with a Legal Plan

Access experienced attorneys to help with estate planning, home sales, tax audits and more.

68% of members

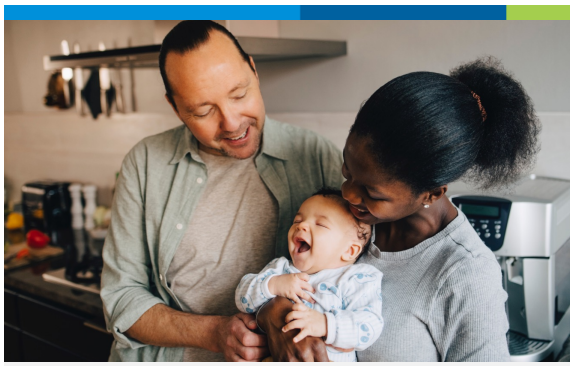
of Legal Plan members say they are on track to achieve their financial goals, compared to 54% of those without a legal plan[2]

70% of Americans

of Americans do not have a will, the most basic estate planning document you need to plan your assets[3]

$9.25 per month

provides personal legal coverage for over 100 different types of common legal issues



Consider these life events:

- Getting married or name change
- Buying, renting or selling a home
- Dealing with identity theft issues
- Assist contacting banks/creditors
- Starting a family or adoption
- Creating wills, or estate planning
- Caring for aging parents
- Sending kids off to college
- Medicaid/Medicare questions
- Security deposit assistance
- Student loan debt assistance

Legal help made easy. See how simple it is to use your plan:

Client Service Center in Cleveland, OH

Over 100+ covered legal matters

Convenient scheduling with attorney

Easy access to member services online or by phone

Educational tools and self-help library online

Your employer has partnered with MetLife Legal Plans to give you access to a nationwide network of attorneys. A legal plan is similar to any other insurance coverage you purchase at work.

To enroll in these benefits, visit www.myclublifeonline.com

Help ensure your personal security with MetLife Legal Plans

Excellent customer service

The website is easy to use to identify plan attorneys by ZIP code; calls to the 800 number are answered promptly, and agents are very knowledgeable. I was able to have two wills, two powers of attorney, two living wills, and two property deed transfers done with no additional charge.

— S.D., MetLife Legal Plans Member[4]



Estate planning at your fingertips

Most of us know we need important estate planning documents like wills, advance directives and powers of attorney, but finding the time to complete these documents can be a challenge. Through our digital estate planning solution we make it easy for you to complete estate planning documents. This allows you to designate your wishes for healthcare, as well as protect your family and assets quickly and easily from the comfort of your home. With our digital estate planning solution you can create:

- **Last Will and Testament:** Leave property to loved ones and choose guardians for minor children.
- **Advance Directive:** Plan for a medical emergency and select medical care preferences.
- **Durable Financial Power of Attorney:** Choose someone to manage finances in case of an emergency.
- **Probate Avoidance Documents:** Keep your home out of the probate process and have it pass directly to the beneficiaries of your choosing with either a transfer on death deed or revocable living trust, depending on your state.

Create wills, living wills and powers of attorney online in as little as 15 minutes

How do I get started?

Our digital estate planning solution is available to all enrolled legal plan members at **www.members.legalplans.com**. You will need to create an account here using the email and password of your choice to use the digital estate planning solution. The process is designed to work for most people, but if there are aspects of your estate that are more complicated, you might be directed to reach out to one of our network attorneys instead of using the online process.

Frequently Asked Questions

How does the plan work?

A. Getting started is easy. You choose an attorney from our network, which is available online or by calling our Client Service Center. Call the attorney you select and schedule a time to talk or meet. It's that simple. You can also choose an attorney outside of our network and be reimbursed according to a set fee reimbursement schedule.[1] You can speak to our network attorneys face to face, by phone or you can submit questions online to our Law Firm E-Panel — whatever works best for you. And for certain legal matters, your attorney can represent you in court without you having to make an appearance.

Can I get help finding the right attorney for my needs?

A. Yes, our Client Service Center representatives are here to help you find the right attorney for your legal matter, whatever that might be. We're committed to ensuring you receive the expert legal help you need, when you need it.

How are attorneys selected for the network? What are their qualifications?

A. We only select attorneys who meet our selection criteria and agree to our Attorney Code of Excellence. Attorneys in the network have an average of 25 years experience in the practice of law, have graduated from an accredited law school and must maintain valid state licensure. Additionally, the attorneys must agree to provide superior customer service to all legal plan members. We routinely monitor our attorneys to ensure our members' needs are being met and conduct regular re-credentialing audit that looks at legal activity, member feedback, verification of malpractice insurance and more.

How much will it cost?

A. Less than you might think. For less than a dollar a day, you can have our legal experts on your side, for as long as you need them.

How do I pay for my coverage?

A. It's easy. Your premium is conveniently paid through payroll deductions, so you don't have to worry about writing a check or missing a payment.

Are my spouse and family members also covered by my plan?

A. Most plans cover your spouse and dependent children; please see the details of your plan. You can confirm the details of your coverage online. If your dependents are included, you can grant online access in account settings.

Are claim forms required when using the legal plan?

A. No. We make using your plan easy. When you use a network attorney, there is nothing for you to do. Plan services are covered in full, and billing is between us and the network attorney. There are no waiting periods, no copays, no deductibles and no claim forms.

Enroll at www.myclublifeonline.com

Questions? Call our Client Service Center
1-800-821-6400

1. Please see your plan description for details. Coverage may vary by state or employer group rate.
2. Source: 2022 MetLife Employee Benefit Trends Study
3. CARAVAN survey conducted by ENGINE on behalf of MetLife Legal Plans, January 2020.
4. This testimonial is for illustrative purposes only.

Group legal plans are administered by MetLife Legal Plans, Inc., Cleveland, Ohio. In California, this entity operates under the name MetLife Legal Insurance Services. In certain states, group legal plans are provided through insurance coverage underwritten by Metropolitan General Insurance Company, Warwick, RI. Some services not available in all states. No service, including consultations, will be provided for: 1) employment-related matters, including company or statutory benefits; 2) matters involving the employer, MetLife and affiliates and plan attorneys; 3) matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents; 4) appeals and class actions; 5) farm and business matters, including rental issues when the participant is the landlord; 6) patent, trademark and copyright matters; 7) costs and fines; 8) frivolous or unethical matters; 9) matters for which an attorney client relationship exists prior to the participant becoming eligible for plan benefits. Coverage for defense of criminal matters is excluded from insurance coverage for individuals located in New York. For all other personal legal matters, an advice and consultation benefit is provided. Additional representation is also included for certain matters. Please see your plan description for details.

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MetLife | Legal Plans

Invited

Cover a wide range of common legal issues with a Legal Plan.

Access experienced attorneys to help with estate planning, home sales, tax audits and more.



Legal assistance for many common life events

Having access to attorneys through a group legal plan empowers you to handle legal matters as they arise. With MetLife Legal Plans, you have easy access to legal help for many common issues — from estate planning to traffic and real estate.

And, considering the average cost to see an attorney is $391 per hour[1], a legal plan can be a cost-effective way to get legal help. In fact, the cost of our legal plan for the whole year is less than the average hourly rate for an attorney.

The cost savings

Example of covered services	Without a legal plan[2]	With a legal plan[3]
Will for employee & spouse	$782	$0 out of pocket
Medical power of attorney	$195	$0 out of pocket
Traffic ticket defense	$782	$0 out of pocket
Home refinancing	$1,955	$0 out of pocket
Total cost of services	**$3,714**	**$240 per year**
Potential savings		**$3,474**

Even if you only use the Legal Plan once in a year, the plan will likely pay for itself. MetLife Legal Plans also provides coverage for many other personal legal matters — such as estate planning, civil litigation defense and identity theft issues.

Consider this scenario:[4]

We have had MetLife Legal Plans for years and used it for wills and defending a civil matter. The service is fantastic and helped us find an attorney that is comforting and thorough. This is perhaps one of the best benefits our company offers, and I have referred people to it whenever questions arise.

To learn more about your coverages and see our attorney network, create an account at members.legalplans.com

Questions? Call our Client Service Center 1-800-821-6400

1. Prices based on the average amount of hours it would take, using the average hourly rate of $391.00 based on years of legal experience, National Law Journal and ALM Legal Intelligence, Survey of Law Firm Economics (2021).
2. Prices based on the average amount of hours it would take, using the average hourly rate of $391.00 based on years of legal experience, National Law Journal and ALM Legal Intelligence, Survey of Law Firm Economics (2021).
3. Cost may vary. This cost is based on an average monthly rate for MetLife Legal Plans of $20.
4. This testimonial is for illustrative purposes only.

Group legal plans are administered by MetLife Legal Plans, Inc., Cleveland, Ohio. In California, this entity operates under the name MetLife Legal Insurance Services. In certain states, group legal plans are provided through insurance coverage underwritten by Metropolitan General Insurance Company, Warwick, RI. For costs and complete details of the coverage, call or write the company. Some services not available in all states. No service, including consultations, will be provided for: 1) employment-related matters, including company or statutory benefits; 2) matters involving the employer, MetLife and affiliates and plan attorneys; 3) matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents; 4) appeals and class actions; 5) farm and business matters, including rental issues when the participant is the landlord; 6) patent, trademark and copyright matters; 7) costs and fines; 8) frivolous or unethical matters; 9) matters for which an attorney client relationship exists prior to the participant becoming eligible for plan benefits. Coverage for defense of criminal matters is excluded from insurance coverage for individuals located in New York. For all other personal legal matters, an advice and consultation benefit is provided. Additional representation is also included for certain matters. Please see your plan description for details.

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MetLife | Legal Plans

Invited

Estate planning legal assistance.

One of the many benefits within your legal plan.



There are several components to an estate plan that are covered with your legal plan:

Will: This most basic estate planning document, ensures that your property will be distributed as intended, and your family will be cared for exactly as you wish. Without a will, the courts may decide how your property is distributed.

Living Trust: A living trust allows you to distribute your assets and property while you are still alive and may reduce the amount of taxes you may have to pay.

Living Will: This document specifies the types of medical treatments you want in the event that you become unable to express those wishes directly. A living will ensures that you get the medical care you want, and protects your loved ones from making difficult medical or end-of-life decisions on your behalf.

Durable Power of Attorney: This document allows you to designate someone to make decisions on your behalf in the event you become incapacitated.

Probate Avoidance Documents: Keep your home out of the probate process and have it pass directly to the beneficiaries of your choosing with either a transfer on death deed or revocable living trust, depending on your state.

The cost savings

Example of covered services	Without a legal plan	With a legal plan
Wills (employee & spouse)	$782	$0 out of pocket
Living trust	$1,955	$0 out of pocket
Living will	$391	$0 out of pocket
Durable power of attorney	$391	$0 out of pocket
Total cost	**$3,519[1]**	**$240 per year[2]**
Potential savings		**$3,279**

Consider this scenario:[4]

My spouse and I decided it was time to do our estate planning. Our attorney in San Francisco made the process easy. He listened to us, what we wanted and made great recommendations on how we can best plan for the future. He explained in simple language all the documents that we were signing.

70%

Seventy percent of Americans don't have a will[1]

To learn more about your coverages and see our attorney network, create an account at members.legalplans.com

Questions? Call our Client Service Center 1-800-821-6400

1. CARAVAN survey conducted by ENGINE on behalf of MetLife Legal Plans, January 2020
2. Prices based on the average amount of hours it would take, using the average hourly rate of $391.00 based on years of legal experience, National Law Journal and ALM Legal Intelligence, Survey of Law Firm Economics (2021).
3. Cost may vary. This cost is based on an average monthly rate for MetLife Legal Plans of $20.
4. This testimonial is for illustrative purposes only.

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MetLife

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MetLife | Legal Plans

Product Overview

Invited



Cover the costs on a wide range of common legal issues with a Legal Plan.

Access experienced attorneys to help with estate planning, identity theft, traffic matters and more.

Powerful legal protection on your side

Quality legal assistance can be pricey. And it can be hard to know where to turn to find an attorney you can trust. With MetLife Legal Plans, you have access to the expert guidance and tools you need to navigate a broad range of personal legal needs. Whether you're starting a family, dealing with identity theft or caring for aging parents, the benefit provides protection at every step.

Reduce the out-of-pocket cost of legal services with MetLife Legal Plans.

How it works

Our service is tailored to your needs. With network attorneys available in person, by phone or by email and online tools to do-it-yourself — we make it easy to get legal help. And, you will always have a choice in which attorney to use. You can choose one from our network of prequalified attorneys, or use an attorney outside of our network and be reimbursed some of the cost.[1]

Best of all, you have unlimited access to our attorneys for all legal matters covered under the plan. For a monthly fee of **$9.25** conveniently paid through payroll deduction, an expert is on your side as long as you need them.

Estate planning at your fingertips

Our website provides you with the ability to create wills, living wills and powers of attorney online in as little as 15 minutes. Answer a few questions about yourself, your family and your assets to create these documents instantly. In states where available, you also have access to sign and notarize your documents online through our video notary feature.[2]

How to use the plan

1. Find an attorney

Create an account at **members.legalplans.com** to see your coverages and select an attorney for your legal matter. Or, give us a call at **800-821-6400** for assistance.

2. Make an appointment

Call the attorney you select and schedule a time to talk or meet.

3. That's it!

There are no copays, deductibles or claim forms when you use a network attorney for a covered matter.

Helping you navigate life's planned and unplanned events.

Invited

For **$9.25 per month**, you, your spouse and dependents get legal assistance for some of the most frequently needed personal legal matters — with no waiting periods, no deductibles and no claim forms when using a network attorney for a covered matter.

Money Matters	• Debt Collection Defense • Identity Theft Defense	• Negotiations with Creditors • Promissory Notes	• Tax Collection Defense
Home & Real Estate	• Boundary or Title Disputes • Deeds • Eviction Defense	• Foreclosure • Mortgages • Property Tax Assessments	• Security Deposit Assistance • Tenant Negotiations
Estate Planning	• Codicils • Complex Wills • Healthcare Proxies • Living Wills	• Powers of Attorney (Healthcare, Financial, Childcare, Immigration)	• Simple Wills
Family & Personal	• Affidavits • Conservatorship • Demand Letters • Divorce (20 hours) • Garnishment Defense	• Guardianship • Immigration Assistance • Name Change • Personal Property Protection	• Protection from Domestic Violence • Review of ANY Personal Legal Document • School Hearings
Civil Lawsuits	• Administrative Hearings • Disputes Over Consumer Goods & Services	• Incompetency Defense	• Small Claims Assistance
Elder-Care Issues	Consultation & Document Review for your parents: • Deeds • Leases	• Medicaid • Medicare • Notes • Nursing Home Agreements	• Powers of Attorney • Prescription Plans • Wills
Traffic & Other Matters	• Defense of Traffic Tickets[3] • Driving Privileges Restoration	• License Suspension Due to DUI	• Repossession

To learn more about your coverages, view our attorney network or grant your dependents access, create an account.

Your account will also give you access to our self-help document library to complete simple legal forms. The forms are available to you, regardless of enrollment.

Create an account at **members.legalplans.com** or scan the QR code.

Questions? Call the **MetLife Legal Plans Client Service Center** at **800-821-6400** Monday—Friday, 8:00 a.m. to 8:00 p.m., ET.

1. The Participant will be reimbursed according to the set fee schedule, the lesser of the maximum reimbursement amount or the attorney's actual charge. You will be responsible to pay the difference, if any, between the plan's payment and the non-plan attorney's charge for services. MetLife Legal Plans is not responsible for legal work performed by out-of-network attorneys.
2. Digital notary and signing is not available in all states.
3. Does not cover DUI.

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