

**APPENDIX B**

**EMPLOYEE BENEFIT BOOKLET**

**Enloe Medical Center**



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**[deltadentalins.com](http://deltadentalins.com)**

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**Group No: 06869**

**Effective Date: January 1, 2024**

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## INTRODUCTION

We are pleased to welcome you to the group dental plan for **Enloe Medical Center**. Your plan is self-funded by your employer and your claims are administered by Delta Dental. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the Provider, but to see him/her on a regular basis.

This Employee Benefit 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 of California ("Delta Dental") and cannot modify the Contract in any way.

### Using This Employee Benefit Booklet

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

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

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

### Contact Us

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

You can access our automated information line at 800-765-6003 during regular business hours to obtain information about Enrollee eligibility and benefits, group benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write us with your question(s), please mail your inquiry to the following address:

DELTA DENTAL OF CALIFORNIA  
560 Mission Street  
Suite 1300  
San Francisco, CA 94105

## DEFINITIONS

Terms when capitalized in your Employee Benefit Booklet have defined meanings, given in the section below or throughout the booklet sections.

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

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

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

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

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

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

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

**Contract Year:** the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

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

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

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

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

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

**Dental Emergency:** Dental screening, examination, and evaluation by a Provider, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Provider, 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.

**Dental Emergency Condition:** a dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate dental attention could reasonably be expected to result in: 1) placing the Enrollee's health in serious jeopardy; 2) causing other serious dental or health consequences, and/or 3) causing serious impairment of dental functionality.

**Dependent Enrollee:** an Eligible Dependent enrolled to receive Benefits.

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

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

**Eligible Employee:** any employee or retiree as eligible for Benefits.

**Enrollee:** an Eligible Employee (“Primary Enrollee”) or an Eligible Dependent (“Dependent Enrollee”) enrolled to receive Benefits.

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

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

**Late Entrant:** an Eligible Employee and/or Eligible Dependent who does not enroll for coverage under the Contract within 31 days of the date first eligible, but later becomes covered; or who requests coverage after previously terminating coverage while still eligible for coverage under the Contract.

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

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

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

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

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

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

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

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

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

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

**Qualifying Status Change:** a change in:

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

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

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

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

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

## **COST OF COVERAGE**

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

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

We may cancel the Contract 30 days after written notice to the Contractholder if the cost of coverage is not paid when due.

## **ELIGIBILITY AND ENROLLMENT**

### **Eligibility Requirements**

An employee becomes eligible on whichever is later, the Effective Date or on the first day of the month following date of hire. Employees hired the 1st day of a calendar month will wait one month for benefits. Employees hired the last day of a calendar month will wait one day for benefits.

You are eligible to participate in this Plan if you are:

1. in active full-time or benefits-eligible part-time employment for the employer, and
2. are regularly scheduled to work at least forty-eight (48) hours of service per pay period.

You will be deemed in "active employment" on each day you are actually performing services for the employer and on each day of a regular paid vacation or on a regular non- working day, provided you were actively at work on the last preceding regular working day. For positions requiring Continuing Education Leave, a maximum forty-eight (48) hours in a fiscal year, will count towards hours worked. You will also be deemed in "active employment" on any day you are absent from work during an approved FMLA leave or solely due to a health factor. An exception applies only on your first scheduled day of work. If you do not report for employment on your first scheduled workday, you will not be considered as having commenced active employment.

Your eligible dependents may also participate. Eligible Dependents include:

1. A legally married spouse, unless legally separated from you. "Legally married" means an eligible employee's legal spouse, whether same-sex or opposite-sex, in a marriage entered into under the laws of a U.S. or foreign jurisdiction having the authority to sanction marriages, but will not include a common law spouse.
2. A registered domestic partner. A registered domestic partnership means a relationship validly established under California Family Code Section 297-297.5. A registered domestic partner means an individual, who has filed, along with the employee, a Declaration of Domestic Partnership with the Secretary of State of California, or a similar declaration issued by another state, and at the time of enrollment in the Plan meets all the following requirements: (1) both persons have a common residence; (2) neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved or adjudicated a nullity; (3)

the two persons are not related by blood in a way that would prevent them from being married to each other in the state of California; (4) both persons are at least 18 years of age; and (5) one or both of the persons are 62 years of age or older and are entitled to Medicare or Social Security.

3. A child from birth to age twenty-six (26).

The term child includes:

- a. your natural child or a natural child of your covered domestic partner;
- b. a stepchild by legal marriage;
- c. a child who is adopted or has been placed with you for adoption by a court of competent jurisdiction;
- d. a child for whom legal guardianship has been awarded;
- e. a child who is the subject of a *Qualified Medical Child Support Order* (QMCSO) dated on or after August 10, 1993. To be "qualified," a state court medical child support order must specify: the name and last known mailing address of the plan participant and each *alternate recipient* covered by the order, a reasonable description of the type of coverage or benefit to be provided to the *alternate recipient*, the period to which the medical child support order applies, and each plan to which the order applies; and
- f. An unmarried child who is incapable of self-sustaining employment by reason of mental or physical disability and is primarily dependent on you for maintenance and support may be added to the Plan during the *open enrollment period*, a special enrollment period, or continue to be covered under this Plan regardless of age, so long as the disability persists, active coverage was maintained prior to the dependent's twenty-sixth (26<sup>th</sup>) birthday (and continuously since the dependent's twenty-sixth (26<sup>th</sup>) birthday in order to elect new coverage), and the disability began before the child reached age twenty-six (26).

In order to continue coverage, you must furnish written proof of the disability within thirty-one (31) days of the child's twenty-sixth (26<sup>th</sup>) birthday. In order to elect new coverage for a disabled dependent during the *open enrollment period* or a special election period, you must furnish written proof that the disability occurred before the dependent's twenty-sixth (26<sup>th</sup>) birthday and also provide written proof of continuous credible medical coverage since the dependent's twenty-sixth (26<sup>th</sup>) birthday. The *plan administrator* may require you to furnish periodic proof of the child's continued disability but not more often than annually. If such proof is not satisfactory to the *plan administrator*, coverage for the child will end immediately.

You may not participate in this Plan as an employee and as a dependent. In addition, a person may not participate in this Plan as a dependent of more than one (1) employee.

No one who is on active duty with the armed forces will be eligible for coverage under this Plan.

### Enrollment Requirements

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

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

- You must enroll within 31 days after the date you become eligible or during an Open Enrollment Period.
- All dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period.
- If you elect dependent coverage, you must enroll all of your Dependent Enrollees for coverage.

- You must pay the cost of coverage in the manner elected by the Contractholder and approved by us. Coverage cannot be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Status Change.
- If you pay the cost of coverage for your Dependent Enrollees, you must pay in the manner elected by the Contractholder and approved by us until your dependents are no longer eligible or until you choose to drop dependent coverage. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.
- If both you and your Spouse are eligible persons, one may not 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.

**Late Entrant**

You and/or your dependents will be considered a Late Entrant if:

- You and/or your Eligible Dependents do not enroll for coverage under the Contract within 31 days of the date first eligible, but later become covered; or
- You request coverage for yourself and/or your Eligible Dependents after previously terminating coverage while you remained eligible for coverage under the Contract.

Benefits for Late Entrants are reduced as shown in Attachment A at the end of this booklet.

**Loss of Eligibility**

Your coverage ends on the earlier of the last day of the month you stop working for the Contractholder, are no longer an Eligible Employee of the Contractholder or immediately when the Contract ends. Your Spouse loses coverage when your coverage ends or when dependent status is lost. Your dependent children lose coverage when your coverage ends or the last day of the month when dependent status is lost.

**Continuation of Benefits**

We will not pay for any services/treatment received after your coverage ends. However, we will pay for covered services incurred while you were eligible if the procedures were completed within 31 days of the date your coverage ended.

A dental service is incurred:

- 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 as required under the Family & Medical Leave Act of 1993 or other applicable state or federal law\*.

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



\*Coverage for you and your dependents is not affected if you take a leave of absence allowed under the Family & Medical Leave Act of 1993 or other applicable state or federal law. If you are currently paying any part of your cost of coverage, you may choose to continue coverage. If you do not continue coverage during the leave, you can resume that coverage on your return to active work as if no interruption occurred.

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

If you are rehired within the same 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 cost of coverage 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 you and your 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.

We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

## **CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED**

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

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

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

## Enrollee Coinsurance

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

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

It is to your advantage to select PPO Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the section titled “Selecting Your Provider” for more 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 in Attachment A. Deductibles apply to all benefits unless otherwise noted. Only the Provider’s fees you pay for covered Benefits will count toward the Deductible.

## Maximum Amount

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

## Pre-Treatment Estimate

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

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

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

## Coordination of Benefits

We coordinate the Benefits under the Contract with your benefits under any other group or pre-paid plan designed to fully integrate with other policies. If this plan is the “primary” plan, we will not reduce Benefits, but if this plan is the “secondary” plan, we determine Benefits after those of the primary plan and will pay the lesser of the amount that we would pay in the absence of any other dental benefit coverage or the Enrollee’s total out-of-pocket cost under the primary plan for Benefits covered under the Contract.

- How do we determine which plan is the “primary” program?
  - (1) The plan covering you as an employee is primary over a plan covering you as a dependent.
  - (2) The plan covering you as an employee is primary over a plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    - a) secondary to the plan covering the insured person as a dependent and
    - b) primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.
  - (3) Except as stated below, when this plan and another plan cover the same child as a dependent of different persons, called parents:
    - a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but
    - b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
    - c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
  - (4) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee 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 Enrollee 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.
  - (5) 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).
  - (6) 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.
  - (7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:
    - a) First, the Benefits of a plan covering the insured person as an employee or Primary Enrollee (or as that insured person’s dependent);

b) Second, the Benefits under the continuation coverage.

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

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

(9) When determination cannot be made in accordance with the above, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

## SELECTING YOUR PROVIDER

### *Free Choice of Provider*

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

### *Locating a PPO Provider*

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

### *Choosing a PPO Provider*

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

### *Choosing a Premier Provider*

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

### *Choosing a Non-Delta Dental Provider*

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

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

## How to Submit a Claim

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

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

DELTA DENTAL OF CALIFORNIA  
P.O. Box 997330  
Sacramento, CA 95899-7339

## Payment Guidelines

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

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

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

## Provider Relationships

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

## CLAIMS APPEAL

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. You have at least 180 days after receiving a notice of denial to request an appeal or grievance by writing to us giving reasons why you believe the denial was wrong. You and your Provider may also ask Delta Dental to examine any additional information provided that may support the appeal or grievance.

Send your appeal or grievance to us at the address shown below:

DELTA DENTAL OF CALIFORNIA  
P.O. Box 997100  
Sacramento, CA 95899

We will send you a written acknowledgment within 5 days upon receipt of the appeal or grievance. We will make a full and fair review and may ask for more documents during this review if needed. 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, we shall consult with a dentist who has appropriate training and experience. The review will be conducted for us 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. We will send the Enrollee a decision within 30 days after receipt of the Enrollee's appeal or grievance.

If the Enrollee believes he/she needs further review of their appeal or grievance, he/she may contact his/her state regulatory agency if applicable. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Enrollee may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if the Enrollee has 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 (EBSA), 200 Constitution Avenue, N.W. Washington, D.C. 20210.

## GENERAL PROVISIONS

### Non-Discrimination

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. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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)
- 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's Customer Service Center at 800-471-0287.

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 997100  
Sacramento, CA 95899  
Telephone Number: 800-471-0287  
Website Address: [deltadentalins.com](http://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>.

### Clinical Examination

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

**Notice of Claim Form**

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

If the form is not furnished by us within 15 days after requested by you or your Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. You or your Provider may download a Claim Form from our website.

**Written Notice of Claim/Proof of Loss**

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

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

**Time of Payment**

Claims payable under the Contract for any loss other than loss for which the Contract provides any periodic payment will be processed no later than 30 days after written proof of loss is received. We will notify you and your Provider of any additional information needed to process the claim within this 30 day period.

**To Whom Benefits Are Paid**

It is not required that the service be provided by a specific dentist. Payment for services provided by a PPO or Premier Provider will be made directly to the dentist. Any other payments provided by the Contract will be made to you. All Benefits not paid to the Provider will be payable to you, the Primary Enrollee, or Dependent Enrollee, or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his or her parent, guardian or other person actually supporting him or her.

**Misstatements on Application: Effect**

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

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 us, we would not in good faith have issued the contract at the same coverage rate. If any misstatement would materially affect the rates, we reserve the right to adjust the coverage rate to reflect your actual circumstances at enrollment.

**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.

**Attachment A  
Deductibles, Maximums and Contract Benefit Levels**

<b>Deductibles &amp; Maximums</b>	
<b>Annual Deductible</b>	\$25 per Enrollee each Calendar Year \$75 per family each Calendar Year
Deductibles waived for	Diagnostic & Preventive and Orthodontic Services
Deductible Carryover	Any annual Deductible amount satisfied by the Enrollee during the last three (3) months of the year will be applied towards the Deductible for the following year.
<b>Annual Maximum</b>	\$1,500 per Enrollee per Calendar Year
<b>Lifetime Orthodontic Maximum</b>	\$1,500 per dependent child Enrollee to age 19 per lifetime

<b>Contract Benefit Levels</b>		
<b>Dental Service Category</b>	<b>Delta Dental PPO Providers<sup>†</sup></b>	<b>Delta Dental Premier and Non-Delta Dental Providers<sup>†</sup></b>
Delta Dental will pay or otherwise discharge the Contract Benefit Level shown below for the following services:		
<b>Diagnostic and Preventive Services</b>	80%	80%
<b>Basic Services</b>	70%	70%
<b>Crowns and Inlay/Onlay Services</b>	65%	65%
<b>Major Services</b>	60%	60%
<b>Orthodontic Services</b>	50%	50%

<sup>†</sup> Reimbursement is based on PPO Contracted Fees for PPO Providers, Premier Contracted Fees for Premier Providers and Program Allowance for Non-Delta Dental Providers.

**Benefits for Late Entrants**

Benefits for Late Entrants are limited until they have been enrolled in the Contract for 12 consecutive months.

<b>Contract Benefit Levels</b>		
<b>Dental Service Category</b>	<b>Delta Dental PPO Providers<sup>†</sup></b>	<b>Delta Dental Premier and Non-Delta Dental Providers<sup>†</sup></b>
Delta Dental will pay or otherwise discharge the Contract Benefit Level shown below for the following services:		
<b>Diagnostic and Preventive Services</b>	80%	80%
<b>Basic Services</b>	70%	70%
<b>Crowns and Inlay/Onlay Services</b>	Not Covered	Not Covered
<b>Major Services</b>	60%	60%
<b>Orthodontic Services</b>	50%	50%

<sup>†</sup> Reimbursement is based on PPO Contracted Fees for PPO Providers, Premier Contracted Fees for Premier Providers and Program Allowance for Non-Delta Dental Providers.



## Attachment B Services, Limitations and Exclusions

**Contractholder:** Enloe Medical Center

**Group Number:** 06869      **Effective Date:** January 1, 2023

### ***Description of Dental Services***

We will pay the Contract Benefit Level shown in Attachment A for the following services:

- **Diagnostic and Preventive Services**

- (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
- (2) Preventive: cleaning (including scaling in the presence of generalized moderate or severe gingival inflammation-full mouth, which is considered to be a Diagnostic and Preventive Benefit, and periodontal maintenance, which is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
- (3) Palliative: emergency treatment to relieve pain.
- (4) Specialist Consultations: opinion or advice requested by a general dentist.
- (5) Professional Visits: visit to a Provider for observation or after regularly scheduled hours.

- **Basic Services**

- (1) Oral Surgery: extractions and other surgical procedures (including pre- and post-operative care).
- (2) General Anesthesia or IV Sedation: when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
- (3) Endodontics: treatment of diseases and injuries of the tooth pulp.
- (4) Periodontics: treatment of gums and bones supporting teeth.
- (5) Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
- (6) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated crowns for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

- **Crowns and Inlay/Onlay Services**

- (1) Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.

- **Major Services**

- (1) Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
- (2) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.

- **Orthodontic Services**

Procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function.

- **Note on additional Benefits during pregnancy**

When an Enrollee is pregnant, We 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 the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

### **Limitations**

Limitations below with age limitations will be subject to exception based on medical necessity.

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

Examples of Optional Services:

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

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

- (2) Exam and cleaning limitations:
  - a) We will pay for oral examinations and cleanings (including scaling in the presence of generalized moderate or severe gingival inflammation-full mouth, periodontal maintenance in the presence of inflamed gums or any combination thereof) no more than twice in a Calendar Year.
  - b) A full mouth debridement is allowed once in a lifetime when the Enrollee has no history of prophylaxis, scaling and root planing, periodontal surgery or periodontal maintenance procedures within three (3) years. When allowed a full mouth debridement counts toward the maintenance frequency in the year provided.
  - c) Note that periodontal maintenance Procedure Codes that include periodontal maintenance are covered as a Basic Benefit and that routine cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth) and full mouth debridement are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
- (3) X-ray limitations:
  - a) We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
  - b) When a panoramic film is submitted with supplemental film(s), We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
  - c) If a panoramic film is taken in conjunction with an intraoral complete series, We consider the panoramic film to be included in the complete series.
  - d) A complete intraoral series and panoramic film are each limited to once every 60 months.

- e) Bitewing x-rays are limited to two (2) times in a Calendar Year when provided to Enrollees under age 18 and one (1) time each Calendar Year for Enrollees age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
  - f) Image capture procedures are not separately allowable services.
- (4) Topical application of fluoride solutions is limited to twice in a Calendar Year.
  - (5) Interim caries arresting medicament application is limited to twice per tooth per Calendar Year.
  - (6) Space maintainer limitations:
    - a) Space maintainers are limited to the initial appliance and are a Benefit for an Enrollee to age 13. However, a distal shoe space maintainer-fixed-unilateral is limited to children eight (8) and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
    - b) Recementation of space maintainer is limited to once per lifetime.
    - c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.
  - (7) Pulp vitality tests are allowed once per day when definitive treatment is not performed.
  - (8) Oral/facial photographic images are covered once per 36 months and diagnostic casts are covered once per lifetime in conjunction with Orthodontic Services only when Orthodontic Services are a covered benefit. If Orthodontic Services are covered, see Limitations as age limits may apply. However, 3D x-rays are not a covered benefit.
  - (9) Sealants are limited as follows:
    - a) through age 8 on permanent first molars if they are without caries (decay) or restorations on the occlusal surface.
    - b) through age 15 on permanent second molars if they are without caries (decay) or restorations on the occlusal surface.
    - c) repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement.
  - (10) Specialist Consultations count toward the oral exam frequency. Screenings of patients or assessments of patients reported individually when covered are limited to only one in a 12-month period and included if reported with any other examination on the same date of service and Provider office.
  - (11) We will not cover replacement of prefabricated crowns within three (3) months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within three (3) months are included in the fee for the original restoration.
  - (12) We will not cover replacement of an amalgam or resin-based composite restorations (fillings) within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.
  - (13) Protective restorations (sedative fillings) are allowed once per tooth every 90 days when definitive treatment is not performed on the same date of service.
  - (14) Therapeutic pulpotomy is limited to once in a 60-month period for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
  - (15) Pulpal therapy (resorbable filling) are limited to once in a 60-month period. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

- (16) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of two (2) initial visits, two (2) interim visits and one (1) final visit.
- (17) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
- (18) Palliative treatment is limited to three (3) visits in a six (6) month period and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.
- (19) Periodontal limitations:
  - a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period for an Enrollee age 15 and older. See note on additional Benefits during pregnancy. No more than two quadrants of scaling and root planing will be covered on the same date of service.
  - b) Periodontal surgery in the same quadrant is limited to once in every 24-month period and includes any surgical re-entry or scaling and root planing performed within 24-months by the same Provider/Provider office.
  - c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants. Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
  - d) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
  - e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
  - f) When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a Basic Service and are limited to once in a 24-month period.
- (20) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.
- (21) The following Oral Surgery procedure is limited to age 19 (or orthodontic limiting age): transseptal fiberotomy/supra crestal fiberotomy, by report.
- (22) The following Oral Surgery procedures are limited to age 19 (or orthodontic limiting age) provided Orthodontic Services are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.
- (23) Frenulectomy and frenuloplasty are only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician, or the frenum is contributing to the presence of a large diastema(s).
- (24) Crowns with no limiting age and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when We determine the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- (25) Core buildup, including any pins, is covered not more than once in any 60 month period.
- (26) Post and core services are covered not more than once in any 60 month period.
- (27) Crown repairs are covered not more than once in a six (6) month period. Crowns, inlays/onlays and fixed bridges include repairs for 24 months following installation.

- (28) Denture Repairs are covered not more than once in any 24-month period except for fixed Denture Repairs which are covered not more than once in any six (6) month period.
- (29) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when We determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if We determine it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Our payment for implant removal is limited to one (1) for implant site per 60 months whether provided under Delta Dental or any other dental care plan.
- (30) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
- (31) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.
- (32) We limit payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
- a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
  - b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to once per arch in a six (6) month period and relining is limited to two (2) per arch in a 12-month period.
- Immediate dentures and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to once per arch in a six (6) month period and relining is limited to two (2) per arch in a 12-month period.
- c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
  - d) Recementation of fixed partial dentures is limited to once in a six (6) month period.
- (33) Limitations on Orthodontic Services:
- a) The maximum amount payable for each Enrollee is shown in Attachment A.
  - b) Benefits for Orthodontic Services will be provided in periodic payments based on the Enrollee's continuing eligibility.
  - c) Benefits are not paid to repair or replace any orthodontic appliance received under this plan.
  - d) Benefits are not paid for orthodontic retreatment procedures.
  - e) Non-orthodontic procedures performed for the purpose of orthodontic treatment are subject to the orthodontic Contract Benefit Level and maximum if covered as Benefits under Our standard processing policies.
  - f) Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
  - g) Benefits for Orthodontic Services are limited to dependent child Enrollees under the age of 19.

- (34) The fees for synchronous/asynchronous teledentistry services are considered inclusive in overall patient management and are not a separately payable service.

**Exclusions**

Exclusions below with age limitations will be subject to exception based on medical necessity.

**We do not pay Benefits for:**

- (1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law, except as provided in Section 1373(a) of the California Health and Safety Code.
- (2) cosmetic surgery or procedures for purely cosmetic reasons.
- (3) maxillofacial prosthetics.
- (4) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
- (5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
- (6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.
- (7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
- (8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- (9) charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
- (10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- (11) fixed bridges and removable partials for Enrollees under age 16.
- (12) interim implants, endodontic endosseous implant and Extraoral implants.
- (13) indirectly fabricated resin-based Inlays/Onlays.
- (14) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- (15) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

- (16) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, or tobacco counseling.
- (17) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- (18) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- (19) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.
- (20) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.
- (21) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- (22) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Services section, if applicable.
- (23) services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves and other tissues) except as provided under the TMJ Benefit section, if applicable.
- (24) missed and/or cancelled appointments.
- (25) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- (26) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- (27) dental case management motivational interviewing and patient education to improve oral health literacy.
- (28) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- (29) extra-oral - 2D projection radiographic image and extra-oral posterior dental radiographic image.
- (30) diabetes testing.
- (31) corticotomy (specialized oral surgery procedure associated with orthodontics).
- (32) Antigen or antibody testing.
- (33) counseling for the control and prevention of adverse oral, behavioral and systemic health effects associated with high-risk substance use.