DeltaCare® USA

Dental Health Care Program for Eligible Employees and Dependents

Certificate of Coverage

NY14B

Underwritten by:
Delta Dental of New York, Inc.
575 Madison Avenue
New York, NY 10022

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

deltadentalins.com

DeltaCare® USA Dental Health Care Plan

This Certificate of Coverage ("Certificate") provides information about Your DeltaCare USA Dental Health Care Plan ("Plan") provided by Delta Dental of New York, Inc. ("Company"), on behalf of itself, and its affiliated companies. To offer these benefits, the Contractholder has entered into a Group Dental Service Contract with the Us.

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

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

Identification Card (ID)
ID cards are not required to receive dental services. However, when You receive dental services, Your Enrollee identification ("ID") number should be provided to Your Dentist. An ID card may be obtained by visiting Our website at deltadentalins .com.

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

Contact Us
For more information, visit Our website at deltadentalins.com or contact Us at:
DeltaCare USA Customer Service
P.O. Box 1803
Alpharetta, GA 30023
800-422-4234

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

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

You must obtain dental benefits from Your assigned Contract Dentist or be referred for Specialist Services.

The insurance evidenced by this Certificate provides DENTAL insurance ONLY.

The telephone number where you may obtain information about Benefits is 800-422-4234.

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Definitions

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

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

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

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

Child, Children: The Subscriber's Children, including any natural, adopted or step-Children, unmarried disabled Children, newborn Children, or any other Children as described in the Eligibility and Enrollment section of this Certificate.

Contract Dentist: A Dentist who provides services in general dentistry and who has agreed to provide Benefits to Enrollees under this Plan. Contract Dentists may provide services either personally, or through associated Dentists, or other technicians or hygienists who may lawfully perform the services.

Contract Orthodontist: A Dentist who specializes in orthodontics and who has agreed to provide Benefits to Enrollees under this Plan.

Contract Specialist: A Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under this Plan.

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

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Certificate.

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

Dependent: The Subscriber's Spouse and Children.

Effective Date: The date the Contract begins or coverage begins.

Emergency Services: 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. Emergency dental care is limited to palliative treatment for the elimination of dental pain.

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

Exclusions: Dental care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

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

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Group: The employer or party that has entered into an agreement with Us as a Contractholder.

Hospital: A short term, acute, general Hospital, which:
- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- 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.);

- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- 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 rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Medically Necessary: See the How to Use the DeltaCare USA Plan section of this Certificate for the definition.

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice, "Member" also means the Member's designee. Member may also be referred to as "Enrollee".

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. The services of Non-Participating Providers are Covered only for Emergency Dental Care or when authorized by Us.

Open Enrollment Period: The time period the Contractholder has established when You may change coverage selections for the next Contract Year.

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

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

Participating Provider: A Provider who has a contract with Us to provide to You. A list of Participating Providers and their locations is available on Our website at www.deltadentalins.com or upon Your request to Us. The list will be revised from time to time by Us.

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

Premium: The amount that must be paid for Your dental insurance coverage.

Primary Care Dentist ("PCD"): A participating dentist who directly provides or coordinates a range of dental services for You.

Provider: An appropriately licensed, registered or certified dentist, dental hygienist, or dental assistant under Title 8 of the New York State Education Law (or other comparable state law, if applicable) that the New York State Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Provider's services must be rendered within the lawful scope of practice for that type of Provider in order to be Covered under the Certificate.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCD to a Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Certificate or otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider.

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

Service Area: A geographic area designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: Cayuga, Cortland, Genesee, Kings, Nassau, New York, Oswego, Queens, Rensselaer, Rockland, Suffolk, Tompkins and Westchester counties within New York State.

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

Specialist: A dentist who focuses on a specific are of dentistry, including oral surgery, endodontia, periodontia, orthodontia and pediatric dentistry, or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse. Spouse also includes a domestic partner.

Subscriber: The person to whom this Certificate is issued.

Us, We, Our: Delta Dental of New York, Inc. and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental investigational (including treatment for a rare disease or a clinical trial).

You, Your: The Member.

Eligibility for Benefits

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

You are eligible to enroll if You meet the eligibility requirements defined by the Contractholder.

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

Dependents include:

1) Your Spouse
2) If You selected parent and Child/Children or family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 19 years of age. Any unmarried Child who is a student at an accredited institution of learning is considered a Child until age 25 and coverage will last until the day in which the Child turns 25 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for

support and You have been appointed the legal guardian by a court order. Foster Children and grandchildren are covered.

- Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.
- If You have a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. If You have individual or individual and Spouse coverage You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional premium within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

Dependents may not be enrolled under more than one eligible employee.

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

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.

Medicare eligibility will not affect Your eligibility or Your Dependent's eligibility.

This Certificate covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under this Certificate also includes the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

- Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists, or
- For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
  a) The affidavit must be notarized and must contain the following:
     - The partners are both 18 years of age or older and are mentally competent to consent to contract;
     - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
     - The partners have been living together on a continuous basis prior to the date of the application;
     - Neither individual has been registered as a member of another domestic partnership within the last six (6) months; and
  b) Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
  c) Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
     - A joint bank account;
     - A joint credit card or charge card;
     - Joint obligation on a loan;
     - Status as an authorized signatory on the partner's bank account, credit card or charge card;
     - Joint ownership of holdings or investments;
     - Joint ownership of residence;
     - Joint ownership of real estate other than residence;
     - Listing of both partners as tenants on the lease of the shared residence;
     - Shared rental payments of residence (need not be shared 50/50);

- Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
- A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
- Shared household budget for purposes of receiving government benefits;
- Status of one (1) as representative payee for the other's government benefits;
- Joint ownership of major items of personal property (e.g., appliances, furniture);
- Joint ownership of a motor vehicle;
- Joint responsibility for child care (e.g., school documents, guardianship);
- Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
- Execution of wills naming each other as executor and/or beneficiary;
- Designation as beneficiary under the other's life insurance policy;
- Designation as beneficiary under the other's retirement benefits account;
- Mutual grant of durable power of attorney;
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

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

If You are responsible for Your Premium:
1) You must enroll within 31 days after the date You become eligible or during an Open Enrollment Period.
2) If You elect Dependent coverage, You must enroll all of Your Dependent Enrollees for coverage.

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

Special Enrollment Periods - Enrollment Changes
After Your Effective Date, You may change Your enrollment during an Open Enrollment Period or during a Special Enrollment Period as a result of a qualifying status change. Qualifying status changes include, but are not be limited to, the following events:
1) Marital status (marriage, divorce, legal separation, annulment or death);
2) 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);
3) Dependent child ceases to satisfy eligibility requirements;
4) Residence (Enrollee moves);
5) Court order requiring dependent coverage;
6) Termination of employment;
7) Termination of another group dental plan;
8) Reduction of hours of employment;
9) Employer contributions toward another group dental plan were terminated for You or Your Dependent's coverage;
10) Any other current or future election changes permitted by Internal Revenue Code Section 125; or
11) Any other changes specified by applicable law or regulation.

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

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

How to use the DeltaCare USA Plan - Choice of Contract Dentist
We will provide Your Plan with Contract Dentists at convenient locations. To enroll, You must select a Contract Dentist from the list of Dentists provided at deltadentalins.com. Enrollees in the same family may collectively select no more than three (3) Contract Dentists. If an Enrollee fails to select a Contract Dentist, or the

Contract Dentist selected becomes unavailable. We will request the selection of another Contract Dentist or will assign that Enrollee to another Contract Dentist.

You may change Your assigned Contract Dentist at any time by contacting the Customer Service at 800-422-4234. Requests to change Your Contract Dentist must be made prior to the 21st of the month for the change to become effective the first day of the following month.

We will provide You written notice of the assignment to another Contract Dentist provided Your Contract Dentist:
1) Is no longer taking further enrollment;
2) No longer participates in the Plan; or
3) Requests, for good cause, that You or Your Dependents be re-assigned to another Contract Dentist.

Any dental treatment in progress must be completed before You change to another Contract Dentist. For example, dental treatment may include:
1) Partial or full dentures for which final impressions have been taken;
2) All work on any tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

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

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

Upon termination of a Contract Dentist's agreement, We will be liable for the completion of dental treatment begun prior to the termination of the agreement. For example, the terminating Contract Dentist will complete:
1) A partial or full denture for which final impressions have been taken; or

2) All work on any tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

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

Medically Necessary Services

We Cover certain Benefits described in this Certificate as long as the dental service, procedure, treatment, test, device, or supply (collectively, "service") is Medically Necessary e.g. procedures such as laboratory processed crowns, periodontal surgical services, orthodontics, fixed prosthodontic services and implant procedures. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:
- Your dental records;
- Our dental policies and clinical guidelines;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of health care professionals in the generally-recognized health specialty involved.

Services will be deemed Medically Necessary only if:
- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of dental practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external Appeal of Our determination that a service is not Medically Necessary.

Benefits, Limitations and Exclusions

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

Copayments and Other Charges

In order to keep Your Plan affordable, this Plan includes certain cost-sharing features. First, not all dental services or procedures may be included under Your Plan. If the procedure is not listed in the Schedules, it is not covered. You will be responsible to pay the Dentist the full charge for any service not included in Your Plan.

Certain procedures require You to pay a Copayment. Copayments are listed in the Schedules and must be paid directly to the treating Dentist. Any charges for broken appointments and visits after normal visiting hours, if covered, are also listed in the Schedules.

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. If You have not received Authorization for treatment from an Out-of-Network Dentist, and We fail to pay that Out-of-Network Dentist, You may be liable to that Dentist for the cost of services. For further clarification, see *"Emergency Services"* and *"Specialist Services"*.

Emergency Dental Services

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

You may seek treatment from a Dentist other than Your Contract Dentist with no referral:

1) During non-business hours, or

2) If You require Emergency Services and are thirty-five (35) miles or more from Your Contract Dentist. You are only responsible for the Copayment(s) for any treatment received relating to the emergency.

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

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics or pediatric dentistry must be:

1) Referred by Your Contract Dentist; and
2) Authorized by Us.

If there is not an available Contract Specialist in the service area, there are no Benefits for Specialist Services.

If the services of a Contract Orthodontist are needed, please refer to the attached Schedules to determine Your Benefits.

Claims for Reimbursement

We encourage You to submit claims for covered Emergency Services or authorized Specialist Services for payment within ninety (90) days of receiving treatment. Claims must be received within one (1) year of the treatment date. The address for claims submission is:

Claims Department
P.O. Box 1810
Alpharetta, GA 30023
or
Submit claims electronically to this email address:
CS-DeltaCare@delta.org

Access to Care and Transitional Care

Referral to a Non-Participating Provider

If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve a Referral to an appropriate Non-Participating Provider. Your Participating Provider must request prior approval of the Referral to a specific Non-Participating Provider. Approvals

of Referrals to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the Referral, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCD, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be covered as if they were provided by a Participating Provider. You will only be responsible for any applicable in-network Cost-Sharing. In the event a Referral is not approved, any services rendered by a Non-Participating Provider will not be Covered.

When a Specialist Can Be Your Primary Care Dentist
If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may ask that a Specialist who is a Participating Provider be Your PCD. We will consult with the Specialist and Your PCD and decide whether the Specialist should be Your PCD. Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCD, the Specialist and You. We will not approve a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will only be responsible for any applicable in-network Cost-Sharing.

Standing Referral to a Participating Specialist
If You need ongoing specialty care, You may receive a "standing Referral" to a Specialist who is a Participating Provider. This means that You will not need a new Referral from Your PCD every time You need to see that Specialist. We will consult with the Specialist and Your PCD and decide whether You should have a standing Referral. Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCD, the Specialist and You. The treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the Specialist to provide your PCD with regular updates on the specialty care provided as well as all necessary medical information. We will not approve a standing Referral to a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a standing Referral to a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were

provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

When Your Provider Leaves the Network
If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates.

In order for You to continue to receive Covered Services for up to 90 days the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

New Members In a Course of Treatment
If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease.

In order for You to continue to receive Covered Services for up to 60 days Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided

by a Participating Provider. You will only be responsible for any applicable in-network Cost-Sharing.

Exclusions

No coverage is available under this Certificate for the following:

Cosmetic Services

We do not Cover cosmetic services or surgery, unless otherwise specified, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeals sections of this Certificate unless medical information is submitted.

Coverage Outside of the United States, Canada or Mexico

We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Dental Care as described in the Certificate.

Experimental or Investigational Treatment

We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

Felony Participation

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.

Government Facility
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

Medical Services
We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

Medically Necessary
In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device, is otherwise Covered under the terms of this Certificate.

Medicare or Other Governmental Program
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

Military Service
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

No-Fault Automobile Insurance
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

Services Not Listed
We do not Cover services that are not listed in this Certificate as being Covered.

Services Provided by a Family Member
We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" means a child, spouse, mother, father, sister or brother of You or Your Spouse.

Services Separately Billed by Hospital Employees
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Services with No Charge
We do not Cover services for which no charge is normally made.

War
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

Workers' Compensation
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

Claim Determinations

Claims
A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for the information on how We coordinate benefit payments when You also have group health coverage with another plan.

Notice of Claim
Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling 800-422-4234 or visiting Our website at deltadentalins.com. Completed claim forms should be sent to the address in the How to Use the DeltaCare USA Plan section of this Certificate. You may also submit a claim to Us electronically by sending it to the e-mail

address in the How to Use the DeltaCare USA Plan section of this Certificate or visiting Our website at deltadentalins.com.

Timeframe for Filing Claims
Claims for services must be submitted to Us for payment within 12 months after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 12-month period, You must submit it as soon as reasonably possible.

Claims for Prohibited Referrals
We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

Claim Determinations
Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

Pre-service Claim Determinations
1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination or Referral), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

   If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Pre-service Reviews**. With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

Post-service Claim Determinations

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period if We deny the claim in whole or in part.

Payment of Claims

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 day of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 30 days (for claims submitted through internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

Grievance Procedures

Grievances

Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues

or concerns You have regarding Our administrative policies or access to Providers.

Filing a Grievance
You can contact Us in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

Grievance Determination
Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances: By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.) In writing, within 15 calendar days of Your Grievance.

Post-Service Grievances: (A claim for a service or a treatment that has already been provided.) In writing, within 30 calendar days of receipt of Your Grievance.

All Other Grievances: (That are not in relation to a claim or request for a service or treatment.) In writing, within 30 calendar days of receipt of Your Grievance.

Grievance Appeals
If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances: The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.

Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.) 15 calendar days of receipt of Your Appeal.

Post-Service Grievances: (A claim for a service or a treatment that has already been provided.) 30 calendar days of receipt of Your Appeal.

All Other Grievances: (That are not in relation To a claim or request for a service or treatment.) 30 business days of receipt of all necessary information to make a determination.

Assistance
If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th floor
New York, NY 10017
Or call toll free: 1-888-614-5400; or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

Utilization Review

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (Retrospective). If You have any questions about the Utilization Review process, please call 800-422-4234. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call 800-422-4234 or visit Our website at deltadentalins.com.

Preauthorization Reviews

1. **Non-Urgent Preauthorization Reviews**. If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have

45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45 day period.

2. **Urgent Preauthorization Reviews**. With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

Concurrent Reviews

1. **Non-Urgent Concurrent Reviews**. Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of 15 calendar days of receipt of part of the requested information or 15 calendar days or the end of the 45-day time period.

2. **Urgent Concurrent Reviews**. For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to

You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or of one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour time period.

Retrospective Reviews
If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

Retrospective Review of Preauthorized Services
We may only reverse a preauthorized treatment, service or procedure on retrospective review when:
- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and

- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

Reconsideration
If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer review if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

Utilization Review Internal Appeals
You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

1. **Out-of-Network Service Denial**. You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of

denial of an out-of-network health service, You, or Your designee, must submit:

- A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
- Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Referral Denial**. You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network Referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
   - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
   - Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

Standard Appeal

1. **Preauthorization Appeal**. If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.
2. **Retrospective Appeal**. If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the

determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

3. **Expedited Appeal**. An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

   If you are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal appeal or an external appeal.

   Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

Full and Fair Review of an Appeal

We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connections with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

Appeal Assistance

If you need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th floor

New York, NY 10017
Or call toll free: 1-888-614-5400; or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

External Appeal

Your Right to an External Appeal
In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Certificate; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
  - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
  - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
  - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

Your Right to Appeal A Determination that A Service Is Not Medically Necessary
If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph above.

Your Right to Appeal A Determination that A Service is Experimental or Investigational

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph above and Your attending Physician must certify that Your condition or disease is one for which:

- Standard health services are ineffective or medically inappropriate; or
- There does not exist a more beneficial standard service or procedure covered by Us; or
- There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation - Your attending Physician should contact the State for current information as to what documents will be considered or acceptable);
- A clinical trial for which You are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

Your Right to Appeal A Determination that a Service is Out-of-Network
If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph above, and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

Your Right to Appeal an Out-of-Network Referral Denial
If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph above.

In addition, Your attending Physician must: certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

The External Appeal Process
You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In

that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, We will provide coverage subject to the other terms and conditions of this Contract. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Contract for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

Your Responsibilities
It is Your responsibility to start the external appeal process.
You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

Coordination of Benefits

This section applies when You also have group dental coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the

remaining expenses. This coordination prevents duplicate payments and overpayments.

Definitions

- **"Allowable expense"** is the necessary, reasonable, and customary item of expense for dental care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.
- **"Plan"** is other group dental coverage with which We will coordinate benefits. The term "plan" includes:
  a) Group dental benefits and blanket or group remittance dental benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
  b) Dental benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
  c) Dental benefits coverage of a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.
- **"Primary plan"** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).
- **"Secondary plan"** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Rules to Determine Order of Payment

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

- If the other plan does not have a provision similar to this one, then the other plan will be primary.

- If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.
- If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
- If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's dental care expenses:
  a) The plan of the parent who has custody will be primary;
  b) If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
  c) If a court decree between the parents says which parent is responsible for the child's dental care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
- If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
- If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more

than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Necessary Information
We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

Our Right to Recover Overpayment
If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans
We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

- If this Certificate is primary, as defined in this section, We will pay benefits first.
- If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.
- If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

Termination of Coverage

Coverage under this Certificate will automatically be terminated on the first of the following to apply:

1. The Group and/or Subscriber has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.
2. The end of the month in which the Subscriber ceases to meet the eligibility requirements as defined by the Group.

3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.
4. For Spouses in cases of divorce, the date of the divorce.
5. For Children, until the end of the month in which the Child turns 19 years of age. For a Child who is a student at an accredited institution of learning, until the end of the month in which the Child turns 25 years of age.
6. The end of the month during which the Group or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.
7. If the Subscriber has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber. However, if the Subscriber makes a misrepresentation of material fact in writing on his or her enrollment application We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Certificate. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.
8. The date that the Group Contract is terminated. If We terminate and/or decide to stop offering a particular class of group contracts, without regard to claims experience or health related status, to which this Certificate, belongs, We will provide the Group and Subscribers at least 30 days prior written notice.
9. The Group has performed an act or practice that constitutes fraud or made a misrepresentation of material fact under the terms of the coverage.
10. The Group has failed to comply with a material plan provision relating to group participation rules. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.
11. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.
12. The date there is no longer any enrollee who lives, resides, or works in Our Service Area.

No termination will prejudice the right to a claim for benefits which arose prior to such termination.

See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage under COBRA.

Extension of Benefits

Upon termination of insurance, whether due to termination of eligibility, or termination of the Certificate, an extension of benefits will be provided for a period of no less than 30 days for completion of a dental procedure that was started before Your coverage ended.

Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA.

Qualifying Events

Pursuant to federal COBRA, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment) You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.
2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
   - Voluntary or involuntary termination of the Subscriber's employment;
   - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
   - Divorce or legal separation from the Subscriber; or
   - Death of the Subscriber; or
   - The Covered employee becoming entitled to Medicare.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
   - Voluntary or involuntary termination of the Subscriber's employment;
   - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
   - Loss of covered Child status under the plan rules;
   - Death of the Subscriber; or
   - The Covered employee becoming entitled to Medicare.

If You want to continue coverage You must request continuation from the Group in writing and make the first Premium payment within the 60-day period following the later of:
1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group.

The Group may charge up to 102% of the Group Premium for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:
1. The date 18 months after the Subscriber's coverage would have terminated because of termination of employment; provided that the Subscriber or their dependents may continue for a total of 29 months if the Member is determined to be disabled under the United States Social Security Act.
2. If You are a covered Spouse or Child the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, You have the right to become covered under the new Group for the balance of the period remaining for Your continued coverage.

Continuation Rights During Active Duty
Under the Uniformed Service Employment and Reemployment Rights Act ("USERRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end due to service in the uniformed services or upon becoming eligible for medical and dental care under federal health insurance by reason of their service. Call or write Your Group to find out if You are entitled to temporary continuation of coverage under USERRA.

The Group may charge up to 102% of the Group Premium for continued coverage. This does not apply if You or Your dependents serve less than 31 days.

Continued coverage under this section will terminate at the earliest of the following:
1. The 24-month period beginning on the date on which the absence begins; or
2. The day after the date on which You or Your Dependent fail to apply for or return to a position of employment.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment unless an exclusion or waiting period would have been imposed under the health plan had coverage not been terminated.
1. This will not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.
2. If You or Your Dependent's coverage under a health plan is terminated by reason of the person having become eligible for federal health insurance for former members of the uniformed services and their dependents, but subsequently do not commence a period of active duty under the order to active duty that established such eligibility because the order is canceled before such active duty commences, any exclusion or waiting period in connection with the reinstatement of coverage will apply to the continued employment in the same manner as if You or Your Dependents had become reemployed upon such termination of eligibility.

General Provisions

Agreements between Us and Participating Providers
Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any dental benefits program.

Assignment
You cannot assign any benefits or monies due under this Certificate to any person, corporation, or other organization. Any assignment of benefits by You will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services.

Changes in This Certificate
We may unilaterally change this Certificate upon renewal, if We give the Group 30 days' prior written notice.

Choice of Law
This Certificate shall be governed by the laws of the State of New York.

Clerical Error
Clerical error, whether by the Group or Us, with respect to this Certificate, or any other documentation issued by us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

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

Conformity with Laws
Any term of this Certificate which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

Continuation of Benefit Limitations
Some of the benefits in this Certificate may be limited to a specific number of visits, a benefit maximum, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

Entire Agreement
This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

Fraud and Abusive Billing
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

Furnishing Information and Audit
The Group and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with certain information over the telephone for reasons such as the following: to determine the level of care You need; so that We may certify care authorized by Your Provider, or make decisions regarding the Medical Necessity of Your care. The Group will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to enrollment at the Group's New York office.

Identification Cards
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits, Your Premiums must be paid in full at the time that the services are sought to be received.

Incontestability
No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument will be deemed representations and not warranties.

Input in Developing Our Policies
Members may participate in the development of Our policies by writing to Delta Dental of New York, Inc., Attn: New York Enrollee Input, P.O. Box 2105, Mechanicsburg, PA 17055-2105.

Material Accessibility
We will give the Group and the Group will give You ID cards, Certificates, riders, and other necessary materials.

More Information about Your Dental Plan
You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or utilization review guidelines.
- Written application procedures and minimum qualification requirements for Providers.

Notice
Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: Delta Dental of New York, Inc., P.O. Box 2105, Mechanicsburg, PA 17055-2105.

Premium Refund
We will give any refund of Premiums, if due, to the Group.

Processing Policies
Schedule A subject to Schedule B explains the services covered under the Program. Contract Dentists use professional judgment to determine appropriate services for Enrollees. Benefits performed by Contract Dentists are provided subject to any Copayments. If a Contract Dentist believes that You or any Enrollee should seek treatment from a Contract Specialist, the Contract Dentist contacts Us for a determination of whether the proposed treatment is a covered Benefit. We will determine whether the proposed treatment requires treatment by a specialist. You may contact Our Customer Service at 800-422-4234 for information regarding the dental care guidelines for DeltaCare USA.

Recovery of Overpayments
On occasion a payment will be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

Renewal Date
The renewal date for the Certificate is the anniversary of the effective date of the Group Contract of each year. This Certificate will automatically renew each year on the renewal date unless otherwise terminated by Us or the Group, as permitted by this Certificate, or by the Group upon 30 days' prior written notice to Us.

Right to Develop Guidelines and Administrative Rules
We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

We review and evaluate new technology according to technology evaluation criteria developed by Our medical directors and reviewed by a designated committee, which consists of health care professionals from various medical specialties. Conclusions of the committee are incorporated into Our medical policies to establish decision protocols for determining whether a service is Medically Necessary, experimental or investigational, or included as a Covered benefit.

Right to Offset

If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

Severability

The unenforceability or invalidity of any provision of this Certificate shall not affect the validity and enforceability of the remainder of this Certificate.

Third Party Beneficiaries

No third party beneficiaries are intended to be created by this Certificate and nothing in the Certificate shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can enforce this Certificate's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate, or to bring an action or pursuit for the breach of any terms of this Certificate.

Time to Sue

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within two (2) years from the date the claim was required to be filed.

Translation Services

Translation services are available under this Certificate for non-English speaking Members. Please contact Us at 800-422-4234 to access these services.

Waiver
The waiver by any party of any breach of any provision of this Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

Who May Change this Certificate
This Certificate may not be modified, amended, or changed, except in writing and signed by Our Chief Operating Officer ("COO") or a person designated by the COO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the COO or person designated by the COO.

Who Receives Payment under this Certificate
Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.

Workers' Compensation Not Affected
The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

Your Dental Records and Reports
In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your dental records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, You automatically give Us or Our designee permission to obtain and use Your dental records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a dental professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a dental professional that We may engage to assist Us in reviewing a treatment or claim; and

- Permit copying of Your dental records by Us.

We agree to maintain Your dental information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

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

1) Twenty-four (24) months, beginning on the date the leave of absence begins, or;
2) 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.

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

We:

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

If you need these services, contact Customer Service at 800-422-4234.

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
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.

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-2022 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 12 months*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 12 months*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 12 months*	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost

D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0704	3-D photographic image - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost
D0709	Intraoral - complete series of radiographic images - image capture only	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 - *member to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *member 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	Application of caries arresting medicament - per tooth - *member to age 19; 1 per 6 month period*	No Cost

D1510	Space maintainer - fixed - unilateral - per quadrant	$60.00
D1516	Space maintainer - fixed - bilateral, maxillary	$60.00
D1517	Space maintainer - fixed - bilateral, mandibular	$60.00
D1520	Space maintainer - removable - unilateral - per quadrant	$70.00
D1526	Space maintainer - removable - bilateral, maxillary .	$70.00
D1527	Space maintainer - removable - bilateral, mandibular	$70.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$12.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$12.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$12.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	$12.00
D1557	Removal of fixed bilateral space maintainer - maxillary	$12.00
D1558	Removal of fixed bilateral space maintainer - mandibular	$12.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *member to age 9*	$60.00

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	$5.00
D2331	Resin-based composite - two surfaces, anterior	$10.00
D2332	Resin-based composite - three surfaces, anterior ...	$15.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$50.00

D2390	Resin-based composite crown, anterior	$60.00
D2391	Resin-based composite - one surface, posterior	$55.00
D2392	Resin-based composite - two surfaces, posterior	$65.00
D2393	Resin-based composite - three surfaces, posterior	$75.00
D2394	Resin-based composite - four or more surfaces, posterior	$85.00
D2510	Inlay - metallic - one surface	$170.00
D2520	Inlay - metallic - two surfaces	$180.00
D2530	Inlay - metallic - three or more surfaces	$190.00
D2542	Onlay - metallic - two surfaces	$185.00
D2543	Onlay - metallic - three surfaces	$195.00
D2544	Onlay - metallic - four or more surfaces	$215.00
D2610	Inlay - porcelain/ceramic - one surface	$295.00
D2620	Inlay - porcelain/ceramic - two surfaces	$330.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$350.00
D2642	Onlay - porcelain/ceramic - two surfaces	$325.00
D2643	Onlay - porcelain/ceramic - three surfaces	$360.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$380.00
D2650	Inlay - resin-based composite - one surface	$195.00
D2651	Inlay - resin-based composite - two surfaces	$220.00
D2652	Inlay - resin-based composite - three or more surfaces	$255.00
D2662	Onlay - resin-based composite - two surfaces	$250.00
D2663	Onlay - resin-based composite - three surfaces	$275.00
D2664	Onlay - resin-based composite - four or more surfaces	$320.00
D2710	Crown - resin-based composite (indirect)	$160.00
D2712	Crown - 3/4 resin-based composite (indirect)	$160.00
D2720	Crown - resin with high noble metal	$320.00
D2721	Crown - resin with predominantly base metal	$220.00
D2722	Crown - resin with noble metal	$260.00
D2740	Crown - porcelain/ceramic	$380.00
D2750	Crown - porcelain fused to high noble metal	$380.00
D2751	Crown - porcelain fused to predominantly base metal	$280.00
D2752	Crown - porcelain fused to noble metal	$320.00

D2753	Crown - porcelain fused to titanium and titanium alloys	$380.00
D2780	Crown - 3/4 cast high noble metal	$380.00
D2781	Crown - 3/4 cast predominantly base metal	$280.00
D2782	Crown - 3/4 cast noble metal	$320.00
D2783	Crown - 3/4 porcelain/ceramic	$380.00
D2790	Crown - full cast high noble metal	$380.00
D2791	Crown - full cast predominantly base metal	$280.00
D2792	Crown - full cast noble metal	$320.00
D2794	Crown - titanium and titanium alloys	$380.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$15.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$15.00
D2920	Re-cement or re-bond crown	$15.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$50.00
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$65.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$75.00
D2930	Prefabricated stainless steel crown - primary tooth	$65.00
D2931	Prefabricated stainless steel crown - permanent tooth	$65.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$85.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$75.00
D2940	Protective restoration	$15.00
D2941	Interim therapeutic restoration - primary dentition	$15.00
D2949	Restorative foundation for an indirect restoration	$65.00
D2950	Core buildup, including any pins when required	$65.00
D2951	Pin retention - per tooth, in addition to restoration	$10.00
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 customize a crown to fit under an existing partial denture framework.	$55.00
D2980	Crown repair necessitated by restorative material failure	$25.00
D2981	Inlay repair necessitated by restorative material failure	$25.00
D2982	Onlay repair necessitated by restorative material failure	$25.00
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	$35.00
D3221	Pulpal debridement, primary and permanent teeth	$40.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$35.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$50.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$50.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$110.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$200.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$350.00
D3331	Treatment of root canal obstruction; non-surgical access	$75.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$75.00
D3333	Internal root repair of perforation defects	$75.00
D3346	Retreatment of previous root canal therapy - anterior	$140.00
D3347	Retreatment of previous root canal therapy - premolar	$230.00

D3348	Retreatment of previous root canal therapy - molar	$380.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$75.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$50.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$50.00
D3410	Apicoectomy - anterior	$130.00
D3421	Apicoectomy - premolar (first root)	$140.00
D3425	Apicoectomy - molar (first root)	$150.00
D3426	Apicoectomy (each additional root)	$90.00
D3430	Retrograde filling - per root	$70.00
D3450	Root amputation - per root	$80.00
D3471	Surgical repair of root resorption - anterior	$130.00
D3472	Surgical repair of root resorption - premolar	$130.00
D3473	Surgical repair of root resorption - molar	$130.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$130.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$130.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$130.00
D3920	Hemisection (including any root removal), not including root canal therapy	$70.00
D3921	Decoronation or submergence of an erupted tooth	$8.00

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	$145.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$85.00

D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$85.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$150.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$90.00
D4245	Apically positioned flap	$175.00
D4249	Clinical crown lengthening - hard tissue	$140.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$345.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$275.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$225.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$75.00
D4270	Pedicle soft tissue graft procedure	$225.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$80.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$225.00
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	$225.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$55.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$45.00
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*	$55.00
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	$40.00
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)- Not Covered

- 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	$335.00
D5120	Complete denture - mandibular	$335.00
D5130	Immediate denture - maxillary	$355.00
D5140	Immediate denture - mandibular	$355.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$295.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$295.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$365.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$365.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$295.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$295.00

D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$365.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$365.00
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$415.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$415.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$295.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$295.00
D5410	Adjust complete denture - maxillary	$12.00
D5411	Adjust complete denture - mandibular	$12.00
D5421	Adjust partial denture - maxillary	$12.00
D5422	Adjust partial denture - mandibular	$12.00
D5511	Repair broken complete denture base, mandibular	$45.00
D5512	Repair broken complete denture base, maxillary	$45.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$25.00
D5611	Repair resin partial denture base, mandibular	$50.00
D5612	Repair resin partial denture base, maxillary	$50.00
D5621	Repair cast partial framework, mandibular	$50.00
D5622	Repair cast partial framework, maxillary	$50.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$50.00
D5640	Replace broken teeth - per tooth	$40.00
D5650	Add tooth to existing partial denture	$40.00
D5660	Add clasp to existing partial denture - per tooth	$50.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$180.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$180.00
D5710	Rebase complete maxillary denture	$100.00
D5711	Rebase complete mandibular denture	$100.00
D5720	Rebase maxillary partial denture	$100.00
D5721	Rebase mandibular partial denture	$100.00

D5725	Rebase hybrid prosthesis	$100.00
D5730	Reline complete maxillary denture (chairside)	$55.00
D5731	Reline complete mandibular denture (chairside)	$55.00
D5740	Reline maxillary partial denture (chairside)	$55.00
D5741	Reline mandibular partial denture (chairside)	$55.00
D5750	Reline complete maxillary denture (laboratory)	$90.00
D5751	Reline complete mandibular denture (laboratory)	$90.00
D5760	Reline maxillary partial denture (laboratory)	$90.00
D5761	Reline mandibular partial denture (laboratory)	$90.00
D5765	Soft liner for complete or partial removable denture - indirect	$90.00
D5820	Interim partial denture (including retentive/ clasping materials, rests, and teeth), maxillary - *limited to 1 in any 12 consecutive months*	$110.00
D5821	Interim partial denture (including retentive/ clasping materials, rests, and teeth), mandibular - *limited to 1 in any 12 consecutive months*	$110.00
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	$380.00
D6211	Pontic - cast predominantly base metal	$280.00
D6212	Pontic - cast noble metal	$320.00
D6240	Pontic - porcelain fused to high noble metal	$380.00
D6241	Pontic - porcelain fused to predominantly base metal	$280.00
D6242	Pontic - porcelain fused to noble metal	$320.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$320.00

D6245	Pontic - porcelain/ceramic	$380.00
D6250	Pontic - resin with high noble metal	$320.00
D6251	Pontic - resin with predominantly base metal	$220.00
D6252	Pontic - resin with noble metal	$260.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$330.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$350.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$280.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$290.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$180.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$190.00
D6606	Retainer inlay - cast noble metal, two surfaces	$210.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$220.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$325.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$360.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$285.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$295.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$185.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$195.00
D6614	Retainer onlay - cast noble metal, two surfaces	$205.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$225.00
D6720	Retainer crown - resin with high noble metal	$320.00
D6721	Retainer crown - resin with predominantly base metal	$220.00
D6722	Retainer crown - resin with noble metal	$260.00
D6740	Retainer crown - porcelain/ceramic	$380.00
D6750	Retainer crown - porcelain fused to high noble metal	$380.00

D6751	Retainer crown - porcelain fused to predominantly base metal	$280.00
D6752	Retainer crown - porcelain fused to noble metal	$320.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$380.00
D6780	Retainer crown - 3/4 cast high noble metal	$380.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$280.00
D6782	Retainer crown - 3/4 cast noble metal	$320.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$380.00
D6784	Retainer crown - titanium and titanium alloys	$380.00
D6790	Retainer crown - full cast high noble metal	$380.00
D6791	Retainer crown - full cast predominantly base metal	$280.00
D6792	Retainer crown - full cast noble metal	$320.00
D6930	Re-cement or re-bond fixed partial denture	$20.00
D6940	Stress breaker	$45.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$60.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	$5.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$8.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$50.00
D7220	Removal of impacted tooth - soft tissue	$60.00
D7230	Removal of impacted tooth - partially bony	$80.00
D7240	Removal of impacted tooth - completely bony	$110.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$130.00
D7250	Removal of residual tooth roots (cutting procedure)	$45.00
D7251	Coronectomy - intentional partial tooth removal	$130.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$120.00
D7280	Exposure of an unerupted tooth	$90.00

D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$90.00
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*	$30.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$85.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$85.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$100.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$100.00
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)	$85.00
D7472	Removal of torus palatinus	$85.00
D7473	Removal of torus mandibularis	$85.00
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
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost
D7970	Excision of hyperplastic tissue - per arch	$75.00
D7971	Excision of pericoronal gingiva	$75.00

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 - *member to age 19* $1,150.00

D8030 Limited orthodontic treatment of the adolescent dentition - *member to age 19* $1,150.00

D8040 Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children* $1,350.00

D8070 Comprehensive orthodontic treatment of the transitional dentition - *member to age 19* $1,900.00

D8080 Comprehensive orthodontic treatment of the adolescent dentition - *member 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	$15.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	$80.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$80.00
D9239	Intravenous moderate (conscious) sedation/ analgesia - first 15 minutes	$80.00
D9243	Intravenous moderate (conscious) sedation/ analgesia - each subsequent 15 minute increment	$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$25.00
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$35.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	$0.00
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*	$100.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$100.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$100.00
D9951	Occlusal adjustment, limited	$50.00
D9952	Occlusal adjustment, complete	$100.00
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 Us. 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 members through age seven following an attempt by the assigned Contract Dentist to treat the member and upon Authorization by Us, less applicable Copayments. The Plan will consider exceptions on an individual basis if a member has a physical or mental impairment, limitation or condition which substantially interferes with that member's ability to have Benefits provided by a Contract Dentist.
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. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions

Exclusions do not apply to procedures listed on Schedule A, Description of Benefits and Copayments, if dental care or treatment is necessary due to congenital disease or anomaly.

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.
2. Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.
3. Services not due to medical or dental necessity, but done solely for cosmetic purposes with the exception of (1) procedure D9975 (external bleaching for home application, per arch), (2) treatment that is due to accident or injury, and directly attributable thereto, or (3) reconstructive surgery necessary because of a congenital disease or anomaly which has resulted in a functional defect.

   This exclusion will not apply if the treatment is approved by an external appeal agent pursuant to Section 4910 of the New York Insurance Law. Refer to ENROLLEE COMPLAINT PROCEDURES and Appendix A, DELTA DENTAL OF NEW YORK'S INTERNAL GRIEVANCE PROCEDURE Rider for additional information.
4. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for members under 16 years of age.
5. Lost, stolen or broken appliances including, but not limited to, full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges) and orthodontic appliances.
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings or to treat abnormal conditions of the temporomandibular joint (TMJ) which are medical in nature, with the exception of procedures D9951 and D9952 as shown on *Schedule A*.

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 or other diagnostic services for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist or an authorized dental specialist (oral surgeon, endodontist, periodontist, pediatric dentist or 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 and over-the-counter drugs.
13. Dental expenses incurred in connection with any dental 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. Composite or ceramic brackets, lingual adaptation of orthodontic bands.
15. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
16. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.
17. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Delta Dental of New York Internal Grievance Procedure

Appendix A

(1) Denial of payment based upon lack of coverage of benefit under the Contract or Enrollee's eligibility status i.e., claim benefit determinations that are not considered Utilization Review under Article 49 of the New York Insurance Law.

If a post-service claim [1] is denied in whole or in part, Delta Dental shall notify the Enrollee and the attending dentist of the denial in writing within thirty (30) days after the claim is filed, unless special circumstances require an extension of time, not exceeding fifteen (15) days, for processing. If there is an extension, the Enrollee and the attending dentist shall be notified of the extension and the reason for the extension within the original thirty (30) day period. If an extension is necessary because either the Enrollee or the attending dentist did not submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information. The Enrollee or the attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specific information. The extension period (15 days) - within which a decision must be made by Delta Dental - will begin to run from the date on which the Enrollee's response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days).

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

If the Enrollee or the attending dentist wants the denial of benefits reviewed, the Enrollee or the attending dentist must write to Delta

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

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

If after review, Delta Dental continues to deny the claim, Delta Dental shall notify the Enrollee and the attending dentist in writing of the decision on the request for review within thirty (30) days of the date the request is received. Delta Dental shall send to the Enrollee or attending dentist a notice, which contains the specific reason or reasons for the adverse determination and reference to the specific Contract provisions on which the benefit determination is based. The notice shall state that the Enrollee is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the Enrollee's claim for benefits. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request). The notice shall state that if the claim denial is based on lack of dental necessity, experimental treatment or a clinical judgment in applying the terms of the Contract, an explanation is available free of charge upon

request by either the Enrollee or the attending dentist. The notice shall also state that the Enrollee has a right to bring an action under ERISA upon completion of Delta Dental's second level of review, and shall state: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If in the opinion of the Enrollee or attending dentist, the matter warrants further consideration, the Enrollee or the attending dentist should advise Delta Dental in writing as soon as possible. The matter shall then be immediately referred to Delta Dental's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta Dental's Dental Affairs Committee if requested by the Enrollee or the attending dentist. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration. The decision of the Dental Affairs Committee shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the state regulatory agency, a designated state administrative review board, or to the courts with an ERISA or other civil action.

(2) *Denial of a covered benefit where the service is not dentally necessary, appropriate or efficient, i.e., claim benefit determinations that are considered Utilization Review under Article 49 of the New York Insurance Law.*

See Attachment One.

ATTACHMENT ONE

Delta Dental of New York's Utilization Review and Internal Appeals Procedures

I. Definitions

A. Clinical Peer Reviewer shall mean a physician who possesses a current and valid non-restricted license to practice medicine or a health care professional other than a licensed physician who: (1) where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession, and (2) is in the same profession and same similar specialty as the Health Care Provider who typically manages the medical condition or disease or provides the Health Care Service or treatment under review.

B. Clinical Standards shall mean those guidelines and standards set forth in the Utilization Review Plan by the Utilization Review Agent whose Adverse Determination is under appeal.

C. Determinations
   1. Adverse Determination shall mean a determination by a Utilization Review Agent that an admission, extension of stay, or other health care service, upon review based on the information provided, is not medically necessary. This determination is the initial utilization review denial.
   2. Final Adverse Determination shall mean an Adverse Determination which has been upheld by a Utilization Review Agent with respect to a proposed Health Care Service following a standard appeal, or an expedited appeal where applicable, pursuant to Section 4904 of the New York Insurance Law. This determination is issued in response to a first level utilization review appeal.
   3. Appeal Determination shall mean a determination by Delta Dental of New York's Dental Affairs Committee that a health care service, upon review based on the information provided, is not medically necessary. This determination is issued in response to a second level utilization review appeal.

D. Enrollee shall mean a person subject to Utilization Review.

E. External Appeal shall mean an appeal conducted by an External Appeal Agent pursuant to Section 4914 of the New York Insurance Law.

F. External Appeal Agent shall mean an entity certified by the superintendent pursuant to Section 4911 of the New York Insurance Law.

G. Health Care Provider shall mean a Health Care Service or a facility licensed pursuant to Article 28, 36, or 47 of the Public Health Law or a facility licensed pursuant to Article 19, 23, 31, or 32 of the Mental Hygiene Law.

H. Health Care Service shall mean: (1) for purposes of appeals requested pursuant to Paragraph two of Subsection b of Section 4910 of Title 2 the New York Insurance Law, Health Care Service shall mean experimental or investigational procedures, treatments or services, including services provided within a clinical trial, and the provision of a pharmaceutical product pursuant to prescription by the patient's attending physician for a use other than those uses for which such pharmaceutical product has been approved for marketing by the Federal Food and Drug Administration to the extent that coverage for such service is prohibited by law from being excluded under the plan, or (2) in all other cases, health care procedures, treatments or services provided by a facility licensed pursuant to Article 28, 36, 44, or 47 of the Public Health Law pursuant to Article 19, 23, 31, or 32 of the Mental Hygiene Law, or provided by a health care professional, and the provision of pharmaceutical products or services or durable medical equipment.

I. Utilization Review shall mean the review to determine whether a Health Care Service that has been provided is being provided or is proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such service, is medically necessary. None of the following shall be considered Utilization Review: (1) denials based on failure to obtain a Health Care Service from a designated or approved Health Care Provider as required under a contract, (2) where any determination is rendered pursuant to Subdivision 3(a) of Section 2807(c) of the Public Health Law, (3) the review of the appropriateness of the application of a particular coding to a patient, including the assignment of diagnosis and procedure, (4) any issues relating to the determination of the amount or extent of payment other than determinations to deny payment based on an Adverse Determination, and (5) any determination of any coverage issues other than whether a Health Care Service is or was medically necessary.

J. Utilization Review Agent shall mean any insurer subject to Article 32 or 43 of the New York Insurance Law performing Utilization Review and any independent Utilization Review Agent performing Utilization Review under contract with such insurer.

K. Utilization Review Plan shall mean: (1) a description of the process for developing the written clinical review criteria, (2) a description of the types of written clinical information which the plan might consider in its clinical review, including but not limited to a set of specific written clinical review criteria, (3) a description of practice guidelines and standards used by a Utilization Review Agent in carrying out a determination of medical necessity, (4) the procedures for scheduled review and evaluation of the written clinical review criteria, and (5) a description of the qualifications and experience of the health care professionals who developed the criteria, who are responsible for periodic evaluation of the criteria and of the health care professionals or others who use the written clinical review criteria in the process of Utilization Review.

II. Standard Claims & Appeals Procedure

A. Claims for Benefits: In the case of a post-service claim [2] which has been denied on the basis that such service was not dentally necessary, Delta Dental shall notify the Enrollee and the attending dentist of its Adverse Determination in writing within a reasonable period of time, but not later than thirty (30) days after the claim is filed. However, this period may be extended one time by Delta Dental for up to fifteen (15) days, if necessary due to the failure of the Enrollee to submit the information necessary to decide the claim. If there is an extension, the Enrollee and the attending dentist shall be notified of the extension and the reason for the extension within the original thirty (30) day period. The notice of extension shall specifically describe the required information, and the Enrollee or the attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specific information. The extension period (15 days) - within which a decision must be made by Delta Dental - will begin to run from the date on which the Enrollee's response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days).

B. Reconsideration of Adverse Determination: In the event the Utilization Review of a claim results in an Adverse Determination, and this determination was made *without attempting to discuss such matter with the attending dentist who specifically recommended the health care service, procedure or treatment*, the attending dentist shall have the opportunity to request a reconsideration of the Adverse Determination. Such reconsideration shall be conducted by the attending dentist and the Clinical Peer Reviewer making the initial determination or a designated Clinical Peer Reviewer if the original Clinical Peer Reviewer cannot be available. If the Adverse Determination is upheld after reconsideration, Delta Dental shall notify the Enrollee of the Adverse Determination as provided below in Section III(A). If the Adverse Determination is overturned after such reconsideration, Delta Dental shall make payment for the Health Care Service(s). Delta Dental's claim payment will serve as notification of the decision.

C. Informal Inquiry Option: If a claim is denied in whole or in part, a Enrollee may make an informal inquiry regarding general program and eligibility questions by contacting Delta Dental via its toll-free number at 1-800-932-0783. Every caller has access to a supervisor if dissatisfied with the response.

D. Non-emergency Appeals of Adverse Determination: In lieu of making an informal inquiry, a Enrollee or his or her attending dentist may choose to appeal the Adverse Determination. The Enrollee may do so within one hundred eighty (180) days, either by writing to Delta Dental or by calling Delta Dental at its toll-free number. Written acknowledgement of the filing of the appeal to the appealing party will be provided to the Enrollee and the attending dentist within fifteen (15) days of the filing of the appeal. The letter or oral request for appeal should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. Both the Enrollee and the attending dentist are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim.

E. Notification of Information Necessary to Conduct the Appeal: If Delta Dental requires information necessary to conduct a standard internal appeal, Delta Dental shall notify the Enrollee and the attending dentist, in writing within fifteen (15) days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, Delta Dental shall request the missing information, in writing, within five (5) business days of receipt of the partial information.

F. The Review: The review shall be conducted for Delta Dental by a Clinical Peer Reviewer who is neither the Clinical Peer Reviewer who made the claim denial that is the subject of the review, nor the subordinate of such individual. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination. If the review is of a claim denial based in whole or in part on a lack of dental 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 in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available on request. In making the review, Delta Dental will not afford deference to the initial Adverse Determination. A clinical examination at Delta Dental's cost may be implemented, along with discussion among dentist consultants. At this point, the Enrollee may also request a hearing.

G. Rendering of Decision on Appeal of Adverse Determination: Delta Dental shall either approve payment for the Health Care Service(s) or make a Final Adverse Determination within thirty (30) days of the date the request for appeal is received. Delta Dental shall advise the Enrollee and the attending dentist of the appeal decision within two (2) days of the rendering of such determination. Notification of a Final Adverse Determination will be provided in accordance with Section III(B) below. If payment is approved, Delta Dental's claim payment will serve as notification of the decision.

H. Appeal to Delta Dental's Dental Affairs Committee: If in the opinion of the Enrollee or the attending dentist the matter warrants further consideration and the Enrollee chooses not to file an External Appeal pursuant to Section 4914 of the New York Insurance Article, the Enrollee or attending dentist should advise Delta Dental in writing as soon as possible. The matter shall be immediately referred to Delta Dental's Dental Affairs Committee. Delta Dental's Dental Affairs Committee, which contains at least one licensed dentist, will review the claim and either approve payment for the Health Care Service or issue an Appeal Determination. If the Dental Affairs Committee requires information necessary to conduct the Internal Appeal, Delta Dental shall notify the Enrollee or attending dentist, in writing within fifteen (15) days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, Delta Dental shall request the missing information, in writing, within five (5) business days of receipt of the partial information. This stage can include a clinical examination, if not done previously, and a hearing before the Dental Affairs Committee if requested. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration. The decision of the Dental Affairs Committee shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the courts with an ERISA or other civil action or the filing of an External Appeal pursuant to Section 4914 of the New York Insurance Article, if the time period for doing so had not previously expired.

III. Distribution of Information to Enrollees/Attending Dentists Upon Entry of Adverse Determination

A. Content of Notification of Adverse Determination. (See Exhibit A, attached hereto). A notice of an initial Adverse Determination will include:

1. The specific reason or reasons for the Adverse Determination including the clinical rationale, if any;

2. Reference to the specific plan provisions on which the Adverse Determination is based;

3. Instructions on how to initiate standard and expedited appeals including a description of the Delta Dental's review procedures and the time limits applicable to such procedures and a statement of the Enrollee's right to bring a civil action under Section 502(a) of ERISA upon

completion of the second level of review of Delta Dental's Internal Appeals Procedure;

4. Instructions on how to initiate an External Appeal pursuant to Section 4914 of the New York Insurance Law;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, a statement that a copy of such will be provided free of charge upon request;
6. If the Adverse Determination is based on dental necessity or experimental treatment or similar exclusion or limit, a statement that an explanation applying the terms of the plan to the Enrollee's medical circumstances is available upon request;
7. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

B. Content of Notification of Adverse Determination on Review i.e., "Final Adverse Determination" (See Exhibit B, attached hereto). If after the claim is reviewed, Delta Dental continues to deny the claim, Delta Dental shall send the Enrollee/attending dentist a notice, which contains:

1. A clear statement describing the basis and clinical rationale for the denial as applicable to the insured including the specific reason or reasons for the determination, reference to the specific plan provisions upon which the Adverse Determination is based;
2. A clear statement that the notice constitutes the Final Adverse Determination;
3. The insured's coverage type;
4. The name and full address of Delta Dental's Utilization Review Agent;
5. Delta Dental's contact person and his or her telephone number;

6. A description of the health care service that was denied, including the dates of the service, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service;
7. A statement that the Enrollee and the attending dentist may be eligible for an External Appeal and the time frames for requesting an appeal;
8. A clear statement written in bolded text that the forty-five (45) day time frame for requesting an External Appeal begins upon receipt of the Final Adverse Determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing the request a second level internal appeal, the time may expire for the Enrollee to request an External Appeal;
9. A copy of the standard description of the External Appeal process as developed jointly by the superintendent and commission, including a form and instructions for requesting an External Appeal; [3]
10. A statement that the Enrollee is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
11. A statement that when the Enrollee completes the second level of Delta Dental's Internal Appeals Procedure, the Enrollee will then have a right to bring an action under Section 502(a) of ERISA;
12. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, a statement that a copy of such will be provided free of charge upon request;
13. If the Adverse Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation applying the terms of the plan to the Enrollee's medical circumstances is available upon request;

14. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

IV. Cooperation with the External Appeal Agent

Delta Dental will facilitate the prompt completion of External Appeal requests by:

A. Transmitting the Enrollee's dental and treatment records pursuant to an appropriately completed release or release signed by the Enrollee or by a person authorized pursuant to law to consent to health care for the Enrollee and, in the case of dental necessity appeals, transmit the clinical standards used to determine medical necessity for the Health Care Service within three (3) business days of receiving notification regarding the identity and address of the certified External Appeal Agent to which the subject appeal is assigned.

B. Providing information requested by the assigned certified External Appeal Agent as soon as is reasonably possible, but in no event shall Delta Dental take longer than two (2) business days to provide the requested information.

C. Providing the form and instructions, developed jointly by the superintendent and commissioner, for the attending dentist to request an External Appeal in connection with a retrospective adverse utilization review determination under Section 4904 of the Insurance Law, within three (3) business days of an attending dentist's request for a copy of the form.

D. In the event that an Adverse Determination is overturned on External Appeal, or in the event that Delta Dental reverses a denial which is the subject of an External Appeal, Delta Dental shall make payment for the Health Care Service which is the basis of the External Appeal to the Enrollee.

E. No fee will be charged by Delta Dental to a Enrollee for an External Appeal.

FOOTNOTES

[1] *Delta Dental does not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining*

dental care. Additionally, Delta Dental does not conduct concurrent review relating to continued or extended health care services, or additional services for an insured undergoing a course of continued treatment.

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

[3] Such information will also be provided by Delta Dental within three business days of a request by a Enrollee or a Enrollee's designee.

EXHIBIT A

Notice of Adverse Determination

This notice, provided to you pursuant to the requirements of Article 49 of the New York Insurance Law and the United States Department of Labor Claims Procedure Regulations constitutes an Adverse Determination of your claim.

Reasons for the Determination

The NOTICE OF PAYMENT OR ACTION attached hereto outlines the specific reason(s) and the specific plan provision(s) on which the determination was based.

Availability of Clinical Review Criteria Relied Upon to Make this Determination

Upon request and free of charge, Delta Dental will provide to you a copy of any internal rule, guideline or protocol, and/or an explanation of the scientific or clinical judgment if relied upon in denying your claim.

Instructions on How to Initiate a Standard Appeal & How to Initiate an External Appeal

If you or your attending dentist want the denial of benefits reviewed, you or your attending dentist must contact Delta Dental, either in writing or by calling Delta Dental's toll-free number, 1-800-932-0783

within one hundred eighty (180) days of the date on this notice. Failure to comply with such requirements may lead to forfeiture of your right to challenge this denial, even when a request for clarification has been made. You should state why the claim should not have been denied. Also, any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. You or your attending dentist are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered initially.

The review shall be conducted for Delta Dental by a Clinical Peer Reviewer who is neither the Clinical Peer Reviewer who made the claim denial that is the subject of the review, nor the subordinate of such individual. If the review of a claim denial is based in whole or in part on a lack of dental 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 in the pertinent field of dentistry who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such dental consultant. The identity of such dental consultant is available upon request whether or not the advice was relied upon. In making the review, Delta Dental will not afford deference to the initial Adverse Determination.

If after review, Delta Dental continues to deny the claim, Delta Dental shall notify you and your attending dentist in writing of the decision on the request for review within thirty (30) days of the date the request is received. Delta Dental shall send you and your attending dentist a notice, similar to this notice. If in the opinion of you or your attending dentist, the matter warrants further consideration, you have two choices: (1) you may continue to avail yourself of Delta Dental's Internal Appeals Procedure and eventually, upon completion of Delta Dental's second level of review, file an action in the courts pursuant to section 502(a) of ERISA; or (2) you may file an External Appeal with the New York Insurance Department. Attached hereto is "Standard Description and Instructions for Health Care Consumers to Request an External Appeal." More information on these two options will be provided to you after you complete the first level of review.

Additional Necessary information which Must be Provided in Order for Delta Dental to Render a Decision on your Appeal

If you should choose to avail yourself of Delta Dental's Internal Appeals Procedure, Delta Dental may require additional information in order to render a decision on your appeal. If this is the case, Delta Dental has attached to this notice a separate sheet containing of a list of such necessary information, which also explains why such material or information is necessary. Please submit such information to the address listed thereon. Please also include any other documents, data information or comments which you believe to have bearing on the claim including this denial notice.

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 **deltadentalins.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)

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