

DeltaCare[®] USA

Dental Health Care Program
for Eligible Employees
and Dependents

NY14A

Combined Evidence of Coverage and Disclosure Form



www.deltadentalins.com

Provided by:

Delta Dental of New York, Inc.
575 Madison Avenue
New York, NY 10022
800-422-4234

EVIDENCE OF COVERAGE DISCLOSURE FORM

DeltaCare USA
Dental Health Care Program

This booklet is a Combined Evidence of Coverage and Disclosure Form (“EOC”) for your DeltaCare USA Dental Health Care Program (“Program”) provided by Delta Dental of New York, Inc. (“Delta Dental”). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract (“Contract”) issued by Delta Dental.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW HOW TO OBTAIN DENTAL BENEFITS.

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

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Definitions

As used in this booklet:

Authorization means the process by which Delta Dental determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

Client means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

Contract Dentist means a Dentist who provides services in general dentistry, and has agreed to provide Benefits to Enrollees under this Contract.

Contract Orthodontist means a Dentist who specializes in orthodontics, and has agreed to provide Benefits to Enrollees under this Contract.

Contract Specialist means a Dentist who provides Specialist Services, and has agreed to provide Benefits to Enrollees under this Contract.

Copayment means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

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

Eligible Dependent means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

Eligible Employee means any employee or group member who is eligible for Benefits as described in this booklet.

Emergency Services mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the patient's health in serious jeopardy.

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

Full-Time Student means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

Open Enrollment Period means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the commencement of the contract term or period as otherwise requested by the Client and agreed to by Delta Dental.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

Specialist Services mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be authorized by Delta Dental.

We, Us or Our means Delta Dental of New York, Inc.

Eligibility for Benefits

Eligible Employees and Eligible Dependents receive Benefits as soon as they are enrolled in the Program. Subject to cancellation as provided under this Program, enrollment of Eligible Employees and Eligible Dependents is for a minimum period of one year.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

- 1) the date the Eligible Employee is eligible for coverage;
- 2) as soon as an Eligible Dependent becomes the dependent of an Eligible Employee, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:

- 1) spouse;
- 2) unmarried children from birth up to age 19;
- 3) unmarried children from 19 to 23 if they are wholly dependent on the Eligible Employee for support and are Full-Time Students.

Full-Time Students who are covered under this program, and are unable to attend school because of an illness, are eligible to continue coverage for one year following the last day of attendance in school. The need for this medical leave of absence must be certified by a medical practitioner licensed to practice in the state of New York. In order to continue coverage, the enrollee must submit this documentation to Delta Dental of New York.

Children include natural children, stepchildren, adopted children and foster children provided all such children are dependent on the Eligible Employee for support. Newborn children are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. If notice is not received within 31 days after the date of birth, coverage of the newborn child becomes effective at the time notice is given.

Newborn adopted children are eligible from and after the moment of birth if physical custody is taken upon the infant's release from the hospital and a petition pursuant to Section 115c of the Domestic Relations Law is filed within 30 days of birth,

provided no notice of revocation of the adoption has been filed pursuant to Section 115b and consent to the adoption has not been revoked. Other legally adopted children are eligible during and after the period of probation.

An unmarried dependent child may continue eligibility if:

- 1) he or she is incapable of self-support or self-sustaining employment because of a mental illness, developmental disability, mental retardation (as defined in the mental hygiene law) or physical handicap that began prior to reaching the limiting age;
- 2) he or she is chiefly dependent on the Eligible Employee for support; and
- 3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Eligible Employee for support.

The dependent child is not required to reside with a parent or legal guardian who is an Enrollee.

Dependents in active military service are not eligible. Medicare eligibility shall not affect eligibility of an Eligible Employee or Eligible Dependent.

Premiums

This Program requires premiums to be paid to Delta Dental. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction, or you will be requested to pay it directly to Delta Dental. The Client will be responsible for sending all payments of premiums to Delta Dental except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare USA Program - Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, we will request the selection of another Contract Dentist or assign you to a Contract Dentist. You may change your assigned Contract Dentist by directing a request to the Customer Service department at 800-422-4234. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment, simply call

your Contract Dentist's facility and identify yourself as a DeltaCare USA Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of providers should be directed to the Customer Service department.

EACH ENROLLEE MUST GO TO THEIR ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED BY DELTA DENTAL, OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Delta Dental terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated Dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you require Emergency Services and are 35 miles or more from your Contract Dentist's facility, or you are unable to reach your Contract Dentist, you may seek treatment from another Dentist. Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of \$100.00 per emergency, per Enrollee. You are responsible for the Copayment(s) as well as any charges over the \$100.00 benefit maximum. Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services

Specialist Services must be referred by the assigned Contract Dentist and authorized by Delta Dental. Delta Dental's review of a request for referral of an Enrollee to a Specialist will be based upon whether the procedure to be performed requires the services of a Specialist or whether the Contract Dentist can and should perform that

procedure. All authorized Specialist Services will be paid by Delta Dental less any applicable Copayments.

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments* and *Orthodontic Limitations and Exclusions* to determine which procedures are covered under this Program.

Services provided by a health care professional not listed within this section are not covered.

Claims for Reimbursement

Claims for covered Emergency Services or Specialist Services must be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90 day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date.

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.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by specialists or out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program.

When Benefits are coordinated with another group insurance policy or group health benefits program, the determination of which policy or program is primary shall be governed by the following rules:

- 1) The policy or program covering the Enrollee as other than a dependent shall be primary over the policy or program covering the Enrollee as a dependent.
- 2) The policy or program covering a child as a dependent of a parent whose birthday occurs earlier in a calendar year shall be primary over the policy or program covering a child as a dependent of a parent whose birthday occurs later in a calendar year (except for a dependent child whose parents are separated or divorced as described in 3 below). If both parents have the same birthday, the plan that covered either of the parents longer is primary. However, if the other policy or program does not have this rule but, instead, has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- 3) In the case of a dependent child whose parents are legally separated or divorced:
 - a) If the parent with custody has not remarried, the policy or program covering the child as a dependent of the parent with custody shall be primary over the policy or program covering the child as a dependent of the parent without custody.

- b) If the parent with custody has remarried, the policy or program covering the child as a dependent of the parent with custody shall be primary over the policy or program covering the child as a dependent of the step-parent, and the policy or program covering the child as a dependent of the step-parent shall be primary over the policy or program covering the child as a dependent of the parent without custody.
 - c) If there is a court decree that establishes financial responsibility for dental services which are Benefits under this Program, and if the plan with responsibility for payment has actual knowledge of the existence of the court decree, notwithstanding (a) and (b), the policy or program covering the child as a dependent of the parent with such financial responsibility shall be primary over any other policy or program covering the child.
- 4) If the primary policy or program cannot be determined by the rules described in (1), (2) or (3), the policy or program which has covered the Enrollee for a longer period of time shall be primary, with the following exception: A policy or program covering the Enrollee as a laid-off or retired employee or the dependent of a laid-off or retired employee shall not be primary under this rule (4) over a policy or program covering the Enrollee as an employee or the dependent of an employee. However, if the provisions of the other policy or program do not include this exception, which results in benefits under neither being primary, then this exception shall not apply.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee shall provide to Delta Dental, and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Delta Dental shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta Dental chooses, the amount of any Benefits paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions. If Delta Dental is secondary, Benefits shall be reduced so that the benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses.

Enrollee Complaint Procedure

Delta Dental shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call Customer Service at 800-422-4234 or the complaint may be addressed in writing to:

Delta Dental of New York, Inc.
Quality Management Department
Administrative Offices
1 Delta Drive
Mechanicsburg, PA 17055

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Client and 4) the Dentist's name and facility location.

Within 10 business days of the receipt of any complaint, a quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that the complainant be referred to a Dentist for a clinical evaluation of the dental services provided.

Delta Dental will make a determination, in writing, within 30 days of receipt of a complaint or shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall be undertaken if a written request for an appeal of the determination is made within 30 days of the date of the written determination. Delta Dental shall undertake a full and fair review upon any request. Delta Dental may require additional documents as it deems necessary in making such a review. Delta Dental shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the decision.

New York Insurance Law gives you the right to request an external appeal when treatment is denied on the basis that the services are not medically necessary or that the services are experimental or investigational in nature.

This provision has limited application to Delta Dental because Delta Dental's determinations are coverage decisions rather than determinations of medical necessity. In light of the nature of dental disease and since dental programs generally cover preventative and basic dental procedures, there are few benefit decisions that involve a serious threat to the Enrollee's life or health. However, a limited number of dental coverage decisions do require a determination of medical necessity. Delta Dental has identified these types of coverage decisions because they are procedures necessary to prevent or treat a serious threat to the Enrollee's life or health ("medically necessary coverage decisions"). Some examples of such procedures are: acute cellulitis resulting from a bacterial infection whose origin is a decayed tooth; or a secondary infection of the oral cavity following the extraction of a tooth.

For complete information regarding Delta Dental's Utilization Review procedures and the External Review process, refer to APPENDIX A, DELTA DENTAL OF NEW YORK'S INTERNAL GRIEVANCE PROCEDURE Rider, which is attached to this booklet.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Enrollee may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if the Enrollee has questions about the rights under ERISA. The Enrollee may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits

This Program renews on the anniversary of the contract term unless Delta Dental provides notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. Delta Dental is not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to any continued coverage option, an Eligible Employee's or Eligible Dependent's enrollment under the Program may be canceled, or renewal of enrollment refused, in the following events:

- 1) Immediately upon loss of eligibility as described in this Contract;
- 2) Upon 15 days written notice if the premiums are not paid by or on behalf of the Enrollee on the date due. However, the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of this Contract upon payment of any unpaid premium;
- 3) Upon 30 days' notice if:
 - a) the Contract is terminated or not renewed; or
 - b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Contract.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

Optional Continuation of Coverage

Enrollees who lose coverage under this Program due to certain "Qualifying Events" are entitled to continue coverage at their own expense if the group is subject to COBRA or New York Insurance Law §4305(e). Domestic Partners and their children are not eligible.

Primary Enrollees and Dependent Enrollees losing coverage due to either of the following Qualifying Events may elect to continue coverage for 18 months following the month in which the event occurs:

- 1) The Primary Enrollee's termination of employment, other than for gross misconduct; or
- 2) The Primary Enrollee's reduction in work hours to less than any minimum required to be eligible under this Program.

Primary Enrollees and their Dependent Enrollees may continue coverage for 29 months if the Primary Enrollee is determined under Title I or Title XVI of the Social Security Act to have been disabled at the time Qualifying Events 1 or 2 above occurred, or to have become so disabled within 60 days after such event occurred, provided notice of such determination is given to your employer during the initial 18 months and within 60 days after the date of determination, and provided further that extended coverage for disability terminates on the first day of the month that begins more than 30 days after the date of the final determination that the person is no longer disabled.

Dependent Enrollees losing coverage due to any of the following Qualifying Events may elect to continue coverage for 36 months following the month in which the event occurs:

- 1) A Primary Enrollee's death;
- 2) A divorce or legal separation from a Primary Enrollee;
- 3) A dependent child's ceasing to qualify as an Eligible Dependent under this Program; or
- 4) A Primary Enrollee's qualification for Medicare benefits.

Anyone who is entitled to elect continued coverage based on more than one Qualifying Event will be limited to continued coverage for a total of 36 months following the date of the first Qualifying Event.

A proceeding in a case under Title 11, United States Code with respect to the Group, which results in a substantial elimination of coverage under this Program (within one year before or one year after the date of commencement of the proceeding) of a retired employee (who retired on or before the date of substantial elimination of coverage), of the spouse and dependent children of a retired employee, or of the surviving spouse of a retired employee, is a Qualifying Event, and the individuals losing coverage may elect to continue coverage until death (in the case of the retired employee or the surviving spouse of the retired employee) or for 36 months after death of the retired employee (in the case of the spouse and dependent children of the retired employee).

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 CDT-2009 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>ENROLLEE PAYS</u>
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0210	Intraoral <i>radiographs</i> - complete series (including bitewings) - <i>limited to 1 series every 24 months</i>	No Cost
D0220	Intraoral - periapical first film	No Cost
D0230	Intraoral - periapical each additional film	No Cost
D0240	Intraoral - occlusal film	No Cost
D0250	Extraoral - first film	No Cost
D0260	Extraoral - each additional film	No Cost
D0270	Bitewing <i>radiograph</i> - single film	No Cost
D0272	Bitewings <i>radiographs</i> - two films	No Cost
D0273	Bitewings <i>radiographs</i> - three films	No Cost
D0274	Bitewings <i>radiographs</i> - four films - <i>limited to 1 series every 6 months</i>	No Cost
D0277	Vertical bitewings - 7 to 8 films	No Cost

D0330	Panoramic film	No Cost
D0415	Collection of microorganisms for culture and sensitivity	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
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i>	No Cost

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis <i>cleaning</i> - adult - <i>1 per 6 month period</i>	No Cost
D1110	<i>Additional prophylaxis cleaning - adult (within the 6 month period)</i>	\$45.00
D1120	Prophylaxis <i>cleaning</i> - child - <i>1 per 6 month period</i>	No Cost
D1120	<i>Additional prophylaxis cleaning - child (within the 6 month period)</i>	\$35.00
D1203	Topical application of fluoride - child - <i>to age 19; 1 per 6 month period</i>	No Cost
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients - <i>child to age 19; 1 per 6 month period</i> ...	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars through age 15</i> .	\$10.00
D1510	Space maintainer - fixed - unilateral	\$60.00
D1515	Space maintainer - fixed - bilateral	\$60.00
D1520	Space maintainer - removable - unilateral	\$70.00
D1525	Space maintainer - removable - bilateral	\$70.00
D1550	Re-cementation of space maintainer	\$12.00
D1555	Removal of fixed space maintainer	\$12.00

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 - $\frac{3}{4}$ 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 substrate	\$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
D2780	Crown - $\frac{3}{4}$ cast high noble metal	\$380.00
D2781	Crown - $\frac{3}{4}$ cast predominantly base metal	\$280.00
D2782	Crown - $\frac{3}{4}$ cast noble metal	\$320.00

D2783	Crown - ¾ 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	\$380.00
D2910	Recement inlay, onlay or partial coverage restoration	\$15.00
D2915	Recement cast or prefabricated post and core	\$15.00
D2920	Recement crown	\$15.00
D2930	Prefabricated stainless steel crown - primary tooth	\$65.00
D2931	Prefabricated stainless steel crown - permanent tooth	\$65.00
D2932	Prefabricated resin crown - <i>anterior primary tooth</i>	\$85.00
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i>	\$75.00
D2940	Sedative filling	\$15.00
D2950	Core buildup, including any pins	\$65.00
D2951	Pin retention - per tooth, in addition to restoration	\$10.00
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i>	\$95.00
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i>	\$70.00
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	\$80.00
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	\$60.00
D2970	Temporary crown (fractured tooth) - <i>palliative treatment only</i>	\$15.00
D2971	Additional procedures to construct new crown under existing partial denture framework	\$55.00
D2980	Crown repair, by report	\$25.00

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	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration)	\$110.00

D3320	Root canal - endodontic therapy, bicuspid tooth (excluding final restoration)	\$200.00
D3330	Root canal - endodontic therapy, molar (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 - bicuspid	\$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, 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/periradicular surgery - anterior	\$130.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	\$140.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	\$150.00
D3426	Apicoectomy/periradicular surgery (each additional root)	\$90.00
D3430	Retrograde filling - per root	\$70.00
D3450	Root amputation, per root	\$80.00
D3920	Hemisection (including any root removal), not including root canal therapy	\$70.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under 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
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 flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$345.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$275.00

D4263	Bone replacement graft - first site in quadrant	\$225.00
D4264	Bone replacement graft - each additional site in quadrant	\$75.00
D4270	Pedicle soft tissue graft procedure	\$225.00
D4271	Free soft tissue graft procedure (including donor site surgery)	\$225.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	\$80.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$55.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$45.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - <i>limited to 1 treatment in any 12 consecutive months</i> ...	\$55.00
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i>	\$40.00
D4910	<i>Additional periodontal maintenance (within the 6 month period)</i> .	\$55.00

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	\$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 any conventional clasps, rests and teeth)	\$295.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$295.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$365.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$365.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$415.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$415.00

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
D5510	Repair broken complete denture base	\$45.00
D5520	Replace missing or broken teeth - complete denture (each tooth) .	\$25.00
D5610	Repair resin denture base	\$50.00
D5620	Repair cast framework	\$50.00
D5630	Repair or replace broken clasp	\$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	\$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
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
D5820	Interim partial denture (maxillary) - <i>limited to 1 in any 12 consecutive months</i>	\$110.00
D5821	Interim partial denture (mandibular) - <i>limited to 1 in any 12 consecutive months</i>	\$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
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	Inlay - porcelain/ceramic, two surfaces	\$330.00
D6601	Inlay - porcelain/ceramic, three or more surfaces	\$350.00
D6602	Inlay - cast high noble metal, two surfaces	\$280.00
D6603	Inlay - cast high noble metal, three or more surfaces	\$290.00
D6604	Inlay - cast predominantly base metal, two surfaces	\$180.00
D6605	Inlay - cast predominantly base metal, three or more surfaces	\$190.00
D6606	Inlay - cast noble metal, two surfaces	\$210.00
D6607	Inlay - cast noble metal, three or more surfaces	\$220.00
D6608	Onlay - porcelain/ceramic, two surfaces	\$325.00
D6609	Onlay - porcelain/ceramic, three or more surfaces	\$360.00
D6610	Onlay - cast high noble metal, two surfaces	\$285.00
D6611	Onlay - cast high noble metal, three or more surfaces	\$295.00
D6612	Onlay - cast predominantly base metal, two surfaces	\$185.00
D6613	Onlay - cast predominantly base metal, three or more surfaces	\$195.00
D6614	Onlay - cast noble metal, two surfaces	\$205.00
D6615	Onlay - cast noble metal, three or more surfaces	\$225.00
D6720	Crown - resin with high noble metal	\$320.00
D6721	Crown - resin with predominantly base metal	\$220.00
D6722	Crown - resin with noble metal	\$260.00
D6740	Crown - porcelain/ceramic	\$380.00
D6750	Crown - porcelain fused to high noble metal	\$380.00
D6751	Crown - porcelain fused to predominantly base metal	\$280.00
D6752	Crown - porcelain fused to noble metal	\$320.00

D6780	Crown - ¾ cast high noble metal	\$380.00
D6781	Crown - ¾ cast predominantly base metal	\$280.00
D6782	Crown - ¾ cast noble metal	\$320.00
D6783	Crown - ¾ porcelain/ceramic	\$380.00
D6790	Crown - full cast high noble metal	\$380.00
D6791	Crown - full cast predominantly base metal	\$280.00
D6792	Crown - full cast noble metal	\$320.00
D6930	Recement fixed partial denture	\$20.00
D6940	Stress breaker	\$45.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated - <i>includes canal preparation</i>	\$95.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer - <i>base metal post; includes canal preparation</i>	\$80.00
D6973	Core buildup for retainer, including any pins	\$65.00
D6976	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i>	\$70.00
D6977	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	\$60.00
D6980	Fixed partial denture repair, by report	\$60.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - deciduous tooth	\$5.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$8.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth .	\$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	Surgical removal of residual tooth roots (cutting procedure)	\$45.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$120.00
D7280	Surgical access 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	Biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i>	\$30.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$85.00

D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$85.00
D7320	Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$100.00
D7321	Alveoplasty 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
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	\$15.00
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 (including bitewings)
- D0322 Tomographic survey
- D0330 Panoramic film
- D0340 Cephalometric film
- D0350 Oral/facial photographic images
- D0470 Diagnostic casts

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

- D0210 Intraoral - complete series (including bitewings)
- D0470 Diagnostic casts

- D8010 Limited orthodontic treatment of the primary dentition\$1,150.00
- D8020 Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19*\$1,150.00
- D8030 Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19*\$1,150.00

D8040	Limited orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i>	\$1,350.00
D8050	Interceptive orthodontic treatment of the primary dentition	\$1,150.00
D8060	Interceptive orthodontic treatment of the transitional dentition	\$1,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i>	\$1,900.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i>	\$1,900.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i>	\$2,100.00
D8660	Pre-orthodontic treatment visit	\$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of <i>removable</i> retainers)	\$275.00
D8999	Unspecified orthodontic procedure, by report - <i>includes treatment planning session</i>	\$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	No Cost
D9220	Deep sedation/general anesthesia - first 30 minutes	\$165.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes	\$80.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	\$165.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	\$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$25.00
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
D9940	Occlusal guard, by report - <i>limited to 1 in 3 years</i>	\$100.00
D9951	Occlusal adjustment, limited	\$50.00
D9952	Occlusal adjustment, complete	\$100.00
D9972	External bleaching - per arch - <i>limited to one bleaching tray and gel for two weeks of self treatment</i>	\$125.00
D9999	Unspecified adjunctive procedure, by report - <i>includes failed appointment without 24 hour notice - per 15 minutes of appointment time</i>	\$10.00

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide specialized services, and are referred by the assigned Contract Dentist, must

be preauthorized by Delta Dental. The Enrollee pays the Copayment specified for such services.

Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees." "Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to the Customer Service department at 800-422-4234.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*.
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional \$100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
 - a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
 - b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9972, External bleaching, per arch, or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.

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, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ) which are medical in nature.
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

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.

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

Toll Free

800-422-4234

Customer Service
12898 Towne Center Drive
Cerritos, CA 90703-8546