



Delta Dental Individual &  
Family™  
**DPO from Delta Dental**  
**Basic Plan for Families**

Combined Policy and Disclosure Form

Provided by:

Delta Dental Insurance Company  
One Delta Drive  
Mechanicsburg, PA 17055-6999  
888-282-8784  
deltadentalins.com

**Notice: Premium may be increased upon the  
renewal date.**

### **Have a complaint or need help?**

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

#### **Delta Dental Insurance Company**

To get information or file a complaint with your insurance company or HMO:

Call Quality Management: **888-282-8784**

Toll Free: **888-282-8784**

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

Mail: P.O. Box 1860

Alpharetta, GA 30023-1860

#### **The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

Call with a question: **1-800-252-3439**

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email:

[ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: MC 111-1A, P.O. Box 12030

Austin, TX 78711-0230

### **¿Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

#### **Delta Dental Insurance Company**

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a Quality Management: **888-282-8784**

Teléfono gratuito: **888-282-8784**

En línea: [deltadentalins.com](http://deltadentalins.com)

Dirección postal: P.O. Box 1860

Alpharetta, GA 30023-1860

#### **El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: **1-800-252-3439**

[Presente una queja en: www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico:

[ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: MC 111-1 A, P.O. Box 12030 Austin, TX 78711-0230

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## Policy

You must elect to enroll any eligible person You wish to cover under this Policy. If an election is not made for an individual or dependent, such person will not be eligible under this Policy.

Your dental plan is underwritten and administered by Delta Dental Insurance Company (“Delta Dental”). We will pay for covered dental services as set forth in this Policy. This Policy is issued in exchange for payment of the first installment of Premium and on the basis of the statements made on Your application. This Policy will remain in force unless otherwise terminated in accordance with its terms, until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where You live.

### **READ YOUR POLICY AND ATTACHMENTS CAREFULLY**

### **TEN (10) DAY RIGHT TO EXAMINE AND RETURN THIS POLICY**

Please read this Policy. If this Policy was solicited by deceptive advertising or negotiated by deceptive, misleading or untrue statements or if You are not satisfied, You may return this Policy within 10 days after You receive it. Mail or deliver it to Us. Any Premium paid will be refunded. This Policy will then be void from its start.

This Policy is issued and delivered in the state of Texas and is governed by its laws. If You move and no longer reside in the State of Texas, please contact Our Customer Service Center at 888-282-8784.

This Policy is signed for Delta Dental Insurance Company as of its Effective Date by:

Delta Dental Insurance Company

A handwritten signature in black ink, appearing to read "Michael G. Hankinson".

Michael G. Hankinson, Esq.; President

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## INTRODUCTION

Delta Dental's goal is to provide You with the highest quality dental care and to help You maintain good dental health. We encourage You not to wait until You have a problem to see the dentist, but to see one on a regular basis.

**NOTICE: YOUR SHARE OF THE PAYMENT FOR DENTAL CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR DENTAL PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.**

### Using This Policy

This Policy discloses the terms and conditions of Your coverage and is designed to help You make the most of Your dental plan. It will help You understand how the dental plan works and how to obtain dental care. Please read this Policy completely and carefully. Keep in mind that "You" and "Your" mean the Enrollees and/or Policyholder who are covered under this Policy. "We," "Us" and "Our" always refer to Delta Dental.

### Contact Us

If You have any questions about Your coverage that are not answered here, please visit Our website at [deltadentalins.com](http://deltadentalins.com) or call Our Customer Service Center at 888-282-8784.

Our website allows You to find Delta Dental Providers, complete a customer service form and register for online services. Our customer service number provides access to Our automated information line and customer service representatives.

If You prefer to write to Us with Your question(s), please mail Your inquiry to the following address:

Delta Dental Insurance Company  
P.O. Box 1809  
Alpharetta, GA 30023-1809

### Identification Number

Please provide the Enrollee's identification ("ID") number to Your Provider whenever You receive dental services. The Enrollee ID number should be included on all claims submitted for payment. ID cards are not required, but if You wish to have one You may obtain one by visiting Our website at [deltadentalins.com](http://deltadentalins.com) or calling Our Customer Service Center at 888-282-8784.

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## DEFINITIONS

The following are definitions of words that have special or technical meanings under this Policy.

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

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

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

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

**Deductible:** a dollar amount that an Enrollee must satisfy for certain covered services before We begin paying for Benefits.

**DPO from Delta Dental Contracted Fee (“DPO Provider’s Contracted Fee”):** the fee for each Single Procedure that a DPO Provider has contractually agreed to accept as payment in full for covered services.

**DPO from Delta Dental Provider (“DPO Provider”):** a Provider who contracts with Us or any other member company of the Delta Dental Plans Association and agrees to accept the DPO from Delta Dental Contracted Fee as payment in full for services provided under a DPO plan. A DPO Provider also agrees to comply with Our administrative guidelines.

**Delta Dental Premier<sup>®</sup> Contracted Fee (“Premier Provider’s Contracted Fee”):** the fee for each Single Procedure that a Premier Provider has contractually agreed to accept as payment in full for covered services.

**Delta Dental Premier Provider (“Premier Provider”):** a Provider who contracts with Us or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental Premier Contracted Fee as payment in full for services provided under a plan. A Premier Provider also agrees to comply with Our administrative guidelines.

**Effective Date:** the original date this Policy starts.

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**Eligible Dependent:** a person who is a dependent of an Eligible Primary as described in this Policy.

**Eligible Primary:** residents of Texas who are legally able to enter into an agreement.

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

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

**Maximum Contract Allowance:** the reimbursement under the Enrollee’s Benefit plan against which We calculate payment and the financial obligation for the Enrollee. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by a DPO Provider is the lesser of the Submitted Fee or the DPO Provider’s Contracted Fee; or
- by a Premier Provider is the lesser of the Submitted Fee or the DPO Provider’s Contracted Fee for a DPO Provider in the same geographic area; or
- by a Non-Delta Dental Provider is the lesser of the Submitted Fee or the DPO Provider’s Contracted Fee for a DPO Provider in the same geographic area.

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

**Policy:** this agreement between Us and the Policyholder including any Attachments. This Policy constitutes the entire agreement between the parties.

**Policy Benefit Level:** the percentage of the Maximum Contract Allowance that We will pay.

**Policyholder:** the Primary Enrollee who enrolls for coverage.

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

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**Premium:** the amount payable to Delta Dental as provided on the application or renewal notice.

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

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

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

**Qualifying Status Change:**

- marital status (marriage, divorce, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, suit for adoption, addition of a stepchild or foster child or death of a child);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee moves);
- medical or dental court order requiring dependent coverage;  
or
- any other current or future election changes permitted by state or federal law.

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

**Spouse:** a person related to or a partner of the Policyholder as defined and as may be required to be treated as a Spouse by the laws of the state where this Policy is issued and delivered.

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

**Teledentistry:** dental services delivered by a dentist acting within the scope of the dentist's license, or by a health professional acting under the dentist's delegation and supervision and within the scope of the health professional's license or certification. Teledentistry includes services delivered through telehealth or telecommunications that may include the use of real-time encounter; live video (synchronous) or information stored and forwarded for subsequent review (asynchronous).



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**Waiting Period:** the amount of time an Enrollee must be enrolled under this Policy for specific services to be covered as described in the Attachments which are part of this Policy. No exceptions or credits are given for prior coverage provided under any plan.

## **ELIGIBILITY AND ENROLLMENT**

An individual may be covered under only one DPO from Delta Dental policy at a time. If an individual is enrolled to receive Benefits as a Primary Enrollee or Dependent Enrollee or another defined term under another DPO from Delta Dental individual policy, said individual is not eligible under this Policy.

### **Eligibility Requirements**

Policyholders electing to enroll Eligible Dependents must enroll them at the time of initial enrollment, within 90 days of initial enrollment or within 31 days of a Qualifying Status Change.

- Dependents are the Policyholder's Spouse and dependent children from birth to age 25.
- Children include natural children, stepchildren, foster children, adopted children, children placed for adoption, children as part of a suit for adoption, and children of Spouse.
- Unmarried grandchild under age 25 who is a dependent of Policyholder or Spouse for federal income tax purposes at the time of application for coverage. Coverage for the grandchild may not be terminated solely because the grandchild is no longer dependent upon Policyholder or Spouse for federal income tax purposes.
- Unmarried dependent child and grandchild under age 25 for whom Policyholder or Spouse is required to insure under a medical or dental support order issued under Chapter 154, Family Code, or enforceable by a court in Texas.
- Newborn infants are eligible from the moment of birth.
- An adopted child will be eligible from the moment the child is part of a suit for adoption.

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- A newborn child, adopted child, and medical or dental support child will automatically be covered for 31 days. To continue coverage after 31 days, notice of birth or notice regarding the suit to adopt and additional Premium, if any, must be received within the 31 day period.
  - If a dependent loses coverage due to a change in the Policyholder's or Spouse's marital status, the dependent must be issued a Policy which most nearly approximates the coverage of the Policy in effect prior to the change in the Policyholder's or Spouse's marital status. The new Policy must be issued without evidence of insurability and will have the same effective date as the Policy under which coverage was afforded prior to the change in marital status. This requirement also applies if Spouse loses coverage due to change in marital status to Policyholder.
  - An overage unmarried dependent child may be eligible if:
    - (1) the child is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
    - (2) the child is chiefly dependent on the Policyholder or Spouse for support and maintenance; and
    - (3) proof of dependent child's disability is provided not later than the 31st day after the date the child attains the limiting age. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Policyholder or Spouse for support because of a mental or physical disability that began before the child reached the limiting age.

Dependents on active military duty are not eligible.

## **Enrollment Period**

Enrollees in this Policy must enroll for a minimum of 12 months. If coverage is voluntarily discontinued, Enrollees are not eligible to be enrolled during the 12 month period immediately following the voluntary termination.

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## Renewal

We will provide 60 days' advance written notice of any change in Premium at renewal.

The Policyholder may keep this Policy in force by timely payment of the Premiums. However, We may refuse renewal due to:

- non-payment of Premiums, subject to the “*Grace Period on Late Payments*” provision;
- fraud or material misrepresentation made by or with the knowledge of the Policyholder or Dependent Enrollee when applying for this coverage or filing a claim for Benefits;
- the Policyholder failing to comply with material provisions of this Policy;
- the Policyholder moving out of the state in which this Policy was issued; or
- We cease to renew all Policies issued on this form to residents of the state where You live.

At least 30 days' notice of any non-renewal action permitted by this clause will be mailed to the Policyholder at the last address shown in Our records. If We fail to provide 30 days' notice of Our intent to terminate coverage, Your coverage will remain in effect until 30 days after notice is given or until the effective date of replacement coverage, whichever occurs first. However, no Benefits will be paid for expenses incurred during any period of time for which Premium has not been paid.

## Termination of Coverage

Policyholders have the right to terminate coverage under this Policy by notifying Us of intent to terminate this Policy. Termination of this Policy and coverage for Enrollees will be effective on the last day of the month that We receive Your request, or the last day of the Policy Year, whichever comes first.

A full refund of Premium is available if a written request for a refund is made within the first 10 days of the Effective Date. After that, all requests for a Premium refund will be prorated based upon the number of days remaining in the Policy Year if Premium has been paid in advance. However, a refund may not be available if Enrollees have received Benefits under this Policy.

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You may keep this Policy in force by timely payment of the Premiums. However, We may terminate coverage due to:

- Enrollee no longer eligible under the terms of this Policy (Note that termination in this case automatically occurs on the last day of the month in which the Enrollee no longer meets eligibility requirements. If You move and no longer reside in the state of Texas, please contact Our Customer Service Center at 888-282-8784.
- non-payment of Premiums, subject to the “*Grace Period on Late Payments*” provision;
- fraud or material misrepresentation made by or with the knowledge of the Policyholder or Dependent Enrollee when applying for this coverage or filing a claim for Benefits; or
- We cease to renew all Policies issued on this form to residents of the state where You live.

If coverage is terminated, We will send a written notice to the Policyholder providing reason(s) why coverage is terminated and the date that coverage will end. We will not pay for services received after Your coverage ends. However, We will pay for the completion of Single Procedures started while You were eligible if they are completed within 31 days of the date coverage ended.

## **Reinstatement**

This Policy may be reinstated with no break in coverage provided We receive the full Premium due within 60 days of the date of the past due Premium. The reinstated Policy will have the same rights as before Your Policy lapsed, unless a change is made to Your Policy in connection with the reinstatement. These changes, if any, will be sent to You to attach to Your Policy.

## **OVERVIEW OF DENTAL BENEFITS**

This section provides information that will give You a better understanding of how this dental plan works and how to make it work best for You.

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## Benefits, Limitations and Exclusions

We will pay for Benefits described in the Attachments that are a part of this Policy. This Policy covers several categories of dental services when a Provider furnishes them and when they are necessary and within the standards of generally accepted dental practice standards. Claims will be processed in accordance with Our standard processing policies. The processing policies may be revised at the beginning of a Calendar Year to comply with annual CDT changes made by the American Dental Association and to reflect changes in generally accepted dental practice standards. We will provide at least 30 days' advance notice of such changes to the Policyholder.

We will use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. If You receive dental services from a Provider outside the state of Texas, the Provider will be paid according to Delta Dental's network payment provisions for said state and according to the terms of this Policy.

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

You may obtain treatment for Benefits even though You are unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by Your physician or Provider providing the dental service.

A covered Benefit appropriately provided through Teledentistry is covered on the same basis and to the same extent that the covered Benefit is provided through an in-person diagnosis, consultation, or treatment.

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## Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, subject to certain limitations, and You are responsible for paying the balance. What You pay is called the enrollee coinsurance (“Enrollee Coinsurance”). You may have to satisfy a Deductible before We will pay Benefits. You pay the Enrollee Coinsurance even after a Deductible has been met.

The amount of Your Enrollee Coinsurance will depend on the type of service and the Provider furnishing the service (see section titled “*Selecting Your Provider*”). Providers are required to collect Enrollee Coinsurance for covered services. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to You, We will be obligated to provide as Benefits only the applicable percentages of the Provider’s fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to Your advantage to select DPO Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for You. Please refer to the section titled “*Selecting Your Provider*” for more information.

## Pre-Treatment Estimates

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

- the date this Policy terminates;
- the date the Enrollee’s coverage ends; or
- the date the Provider’s agreement with Delta Dental ends.

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

## SELECTING YOUR PROVIDER

### Free Choice of Provider

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

### Locating a DPO Provider

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

### Choosing a DPO Provider

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

### Choosing a Premier Provider

A Premier Provider is a Delta Dental Provider; however, the Premier Provider has not agreed to the features of the DPO plan. The amount charged may be above that accepted by DPO Providers, and You will be responsible for balance billed amounts. Payment for covered services performed by a Premier Provider is based on the Maximum Contract Allowance, and You may be balance billed up to the Premier Provider's Contracted Fee.

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## Choosing a Non-Delta Dental Provider

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

## Additional Obligations of DPO and Premier Providers

- The DPO Provider or Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Us after satisfaction of the Deductible and Enrollee Coinsurance. You do not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The DPO Provider or Premier Provider will complete the dental Claim Form and submit it to Us for reimbursement.
- The DPO Provider will accept DPO Provider's Contracted Fee as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and DPO Provider's Contracted Fees.

## How to Submit a Claim

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

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

Delta Dental Insurance Company  
P.O. Box 1809  
Alpharetta, GA 30023-1809



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## Payment Guidelines

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

If You or Your Provider file a claim for services later than the time proof of loss is otherwise required, payment may be denied (see section titled “*Written Notice of Claim/Proof of Loss*”). If the services were received from a Non-Delta Dental Provider, You are still responsible for the full cost. If the payment is denied because Your DPO or Premier Provider failed to submit the claim on time, You may not be responsible for that payment. However, if You did not tell Your DPO or Premier Provider that You were covered under a Delta Dental Policy at the time You received the service, You may be responsible for the cost of that service.

If You have any questions about any dental charges, processing policies and/or how Your claim is paid, please contact Us.

## Provider Relationships

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

## COMPLAINTS AND APPEALS OF ADVERSE DETERMINATIONS

### Complaint

A “Complaint” means any dissatisfaction by an Enrollee, physician, Provider or other person designated to act on behalf of the Enrollee orally or in writing about any aspect of Our operations, including but not limited to dissatisfaction with administration; procedures; denial, reduction or termination of services for reasons not related to medical necessity; disenrollment decisions or the quality of dental services performed by a DPO Provider. A Complaint does not include a misunderstanding or problem of misinformation which can be promptly resolved by supplying correct information to the Enrollee’s satisfaction.

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A “Complainant” is an Enrollee, physician, Provider or other person designated to act on behalf of the Enrollee, who files a Complaint.

The Complainant may call the Customer Service Center at 888-282-8784, or the Complaint may be addressed in writing to:

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

## **Complaint Information**

Written Complaints must include: 1) the name of the patient; 2) the name, address, telephone number and ID number of the Enrollee; and 3) the dentist’s name and facility location.

Should an Enrollee choose to have a physician, Provider or other person act on the Enrollee’s behalf during the Complaint process, the Enrollee must provide Us with express written permission designating that individual as their representative and include a signed release, compliant with HIPAA, authorizing the disclosure of confidential information such as their personal health information (PHI).

We will provide notification of any dental services are not covered Benefits, stating the specific contract provision(s).

Within 5 business days after receipt of an oral or written Complaint, the quality management coordinator will send a letter acknowledging the date of receipt of the Complaint, and a description of Our Complaint procedures, estimated time frames for resolution of Complaints, and a request for any necessary information. If the Complaint was received orally, the acknowledgement will include a one-page Complaint form with instructions to return for resolution of the Complaint. Processing of a Complaint will generally not begin until We receive the information shown above, except as noted below for Complaints involving Emergency Dental Services.

The Complainant may call the Customer Service Center at 888-282-8784 at any time between 8:00 a.m. and 8:00 p.m., Central Time, to discuss the Complaint. Complaints requiring professional expertise will be referred to a licensed dental consultant or, if necessary, the dental director for response.

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Certain Complaints may also require a second opinion for a clinical evaluation of dental services provided. Second opinions will be provided by another DPO Provider's facility, unless otherwise authorized by Our dental consultant. We will pay for a second opinion that We have authorized.

We will resolve a Complaint involving Emergency Dental Services (involving emergency care denials, denials of care for life-threatening conditions, and denials of continued stays for hospitalization) within 24 hours after Our receipt. Complaints that do not involve Emergency Dental Services will be resolved within 30 calendar days after receipt. We will send to the Complainant a written report which describes the Complaint and Our resolution. The report will contain a statement of the specific clinical and/or contractual reasons for the resolution and will advise the Complainant of:

- 1) the specialization of any dentist or other Provider consulted,
- 2) a description of Our Complaint procedure, and
- 3) the time frames for Our Appeal process and final decision.

## **Complaint Appeal**

In the event a Complainant is not satisfied with Our resolution of a Complaint, the Complainant will have the right to Appeal the decision before a Complaint Appeal panel. Within 5 business days after receipt of a request for an Appeal, We will send a letter acknowledging the date of receipt of the request and include a statement of the Complainant's rights to:

- 1) appear before an Appeal panel in person (or through a representative if a minor or disabled) in the area where the Enrollee received the care or at an agreed upon location, or
- 2) write to an Appeal panel,
- 3) present alternative expert testimony,
- 4) present oral or written information, and
- 5) question those responsible for the prior resolution.

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Our Appeal panel is composed of Enrollee representatives, DPO Provider representatives and Delta Dental representatives in equal numbers. DPO Providers cannot review a case in which they rendered care or a case they reviewed during Our Complaint or Appeal process. The panel will include a dentist of the appropriate specialty if the quality of specialty care is at issue. Our employees cannot serve as Enrollee members.

No later than 5 business days before the scheduled meeting of the Appeal panel, unless the Complainant agrees otherwise, We will provide to the Complainant or the Complainant's designated representative:

- 1) any documentation to be presented to the panel by Us,
- 2) the specialization of any Providers consulted during the investigation of the Appeal, and
- 3) the name and affiliation of each Delta Dental representative on the panel.

We will send a written resolution of the Appeal within 30 calendar days after receipt of an Appeal. Investigation and resolution of Appeals involving ongoing Emergency Dental Services will be concluded in accordance with the dental immediacy of the case, but no later than 24 hours after receipt of request for Appeal. At the request of the Enrollee, We will provide, instead of an Appeal panel, a Provider who has not previously reviewed the case and who is of the same or similar specialty as ordinarily manages the procedure or treatment under Appeal. The Provider reviewing the Appeal may interview the Enrollee or the Enrollee's designated representative and will make a decision on the Appeal. Initial notice of decision of the Appeal may be delivered orally, but will be followed by a written notice of the determination within 3 days.

Notice of Our final decision will include a statement of the specific clinical and/or contract provision(s) on which the decision was based, and the toll-free telephone number and address of the Texas Department of Insurance.

## **Adverse Determination**

An "Adverse Determination" is a determination by Us that the health care services provided or proposed to be provided to an Enrollee are not medically necessary or appropriate or are experimental or investigational.

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## Adverse Determination Information

In all instances of a utilization review Adverse Determination, written notification of the Adverse Determination will include:

- 1) the principal reasons for the Adverse Determination;
- 2) the clinical basis for the Adverse Determination;
- 3) a description or the source of the screening criteria that were utilized as guidelines in making the determination;
- 4) the professional specialty of the dentist that made the Adverse Determination;
- 5) a description of the procedures for Our Complaint system;
- 6) a description of Our Appeal process;
- 7) a copy of the request for a review by an Independent Review Organization (IRO) form, available at [www.tdi.texas.gov/forms](http://www.tdi.texas.gov/forms);
- 8) notice of the independent review process with instructions that:
  - A) request for a review by an IRO form must be completed by the Enrollee, an individual acting on behalf of the Enrollee, or the Enrollee's Provider of record and be returned to Us that made the Adverse Determination to begin the independent review process; and
  - B) the release of medical information to the IRO, which is included as part of the independent review request for a review by an IRO form, must be signed by the Enrollee or the Enrollee's legal guardian; and
- 9) a description of the Enrollee's right to an immediate review by an IRO and of the procedures to obtain that review for an Enrollee who has a life-threatening condition.

## Adverse Determination Appeal

An "Appeal of Adverse Determination" or "Appeal" is a Complaint concerning dissatisfaction with an Adverse Determination, but does not include a Complaint regarding dissatisfaction with administration; procedures; denials, reduction or termination of services for reasons not related to medical necessity; disenrollment decisions, or the quality of dental service performed by a DPO Provider.

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Unless the specific subscriber agreement allows additional time to respond, within one hundred eighty (180) days of receipt of an Adverse Determination, an Enrollee, Provider, or other person designated to act on behalf of the Enrollee may call the Customer Service Center at 888-282-8784, or the Appeal may be addressed in writing to the address above.

An “Appealing Party” is an Enrollee, physician, Provider or other person designated to act on behalf of an Enrollee, who may request reconsideration of an Adverse Determination.

Written Appeals must include: 1) the name of the patient; 2) the name, address, telephone number and ID number of the Enrollee; and 3) the dentist's name and facility location.

Should an Enrollee choose to have a physician, Provider or other person act on the Enrollee's behalf during the Appeal process, the Enrollee must provide Us with express written permission designating that individual as their representative and include a signed release, compliant with HIPAA, authorizing the disclosure of confidential information such as their personal health information (PHI).

We will provide notification of any dental services are not covered Benefits, stating the specific contract provision(s).

Within 5 business days after receipt of an oral or written Appeal, the quality management coordinator will send a letter acknowledging the date of receipt of the Appeal, and a description of Our Appeal procedures, estimated time frames for resolution of Appeals, and a request for any necessary information. If the Appeal was received orally, the acknowledgement will include a one-page Appeal form with instructions to return for prompt resolution of the Appeal. Processing of an Appeal will generally not begin until We receive the information shown above, except as noted below for Appeals involving Emergency Dental Services.

The Appealing Party may call the Customer Service Center at 888-282-8784 at any time between 8:00 a.m. and 8:00 p.m., Central Time, to discuss the Appeal. Appeals requiring professional expertise will be referred to a licensed dental consultant or, if necessary, the dental director for response. Certain Appeals may also require a second opinion for a clinical evaluation of dental services provided. Second opinions will be provided by another DPO Provider's facility, unless otherwise authorized by Our dental consultant. We will pay for a second opinion that We have authorized.

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We will resolve an Appeal involving Emergency Dental Services (involving emergency care denials, denials of care for life-threatening conditions, and denials of continued stays for hospitalization) within 24 hours after Our receipt. Appeals that do not involve Emergency Dental Services will be resolved within 30 calendar days after receipt. We will send to the Appealing Party a written report which describes the Appeal and Our resolution. The report will contain a statement of the specific clinical and/or contractual reasons for the resolution and will advise the Appealing Party of:

- 1) the specialization of any dentist or other Provider consulted,
- 2) a description of Our Appeal procedure, and
- 3) the time frames for Our Appeal process and final decision.

Notice of Our decision on an Appeal for Adverse Determination will include a statement of the specific clinical and/or contract provision(s) on which the decision was based, and the toll-free telephone number and address of the Texas Department of Insurance.

## **Independent Review**

In the event an Appealing Party is not satisfied with Our resolution of an Appeal, or if the Appeal relates to emergency care denials, denials of care for life-threatening conditions, and denials of continued stays for hospitalization, the Appealing Party has the right to file for review by an independent review organization or "IRO." The Enrollee, Provider, or someone acting on behalf of the Enrollee may file for independent review by sending a REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION (IRO) form to Us at the address listed above. Upon receipt of an IRO request form, We will notify the Texas Department of Insurance within one (1) working day. Within three (3) working days, We will provide the IRO with copies of all relevant documents. We will comply with the IROs determination with respect to the medical necessity or appropriateness, or the experimental or investigational nature, of the health care items and services requested by the Enrollee.

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## Texas Department of Insurance

Any Enrollee, including an Enrollee who has attempted to resolve a Complaint through the Complaint process described above, may file a complaint with the Texas Department of Insurance at P.O. Box 12030, Austin, Texas 78711-2030. The Department's toll-free telephone number is 800-252-3439.

The commissioner will investigate a complaint against Us to determine Our compliance with the insurance laws within 60 days after the Department receives the complaint and all information necessary for the Department to determine compliance. The commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

- 1) additional information is needed;
- 2) an on-site review is necessary;
- 3) We, the Provider, or the complainant do not provide all documentation necessary to complete the investigation; or
- 4) other circumstances beyond the control of the Department.

We will not engage in any retaliatory action (including termination or refusal to renew a contract) against a Policyholder, an Enrollee, or a dentist (on behalf of an Enrollee) for filing a complaint or appealing a decision.

## PREMIUM PAYMENT RESPONSIBILITIES

Your Premium is determined by the plan design chosen at the time of enrollment and by the age of Enrollees. The Policyholder is responsible for making Premium payments when submitting an application for enrollment under this Policy. Each Premium is to be paid on or before its due date. A due date is the day following the last day of the period for which the preceding Premium was paid. You may pay Your Premium by visiting Our website at [deltadentalins.com](http://deltadentalins.com) or by mailing payment to the address below:

Delta Dental Insurance Company  
P.O. Box 660138  
Dallas, TX 75266-0138



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## Rate Guarantee

Your Premium rate is guaranteed for each Policy Year based upon the new Enrollee rates in force at the time of Your enrollment. However, the rate guarantee can be less than a Policy Year if an Enrollee has an Effective Date mid-year due to a Qualifying Status Change or if an Enrollee reaches age 18 during a Policy Year. If an Enrollee reaches age 18 during a Policy Year, the new Premium becomes effective with the next invoice following the 18<sup>th</sup> birthday.

Unless there is a change in Premium due to age or due to Our liability being changed by law or regulation, no change in Premiums will become effective within a Policy Year. A change in law or regulation may include a state and/or federal mandated change or a new or increased tax, assessment or fee imposed on the amounts payable to, or by, Us under this Policy or any immediately preceding Policy between Delta Dental and You. We would provide 30 days' written notice to You, and this Policy will thereby be modified on the date set forth in the notice.

## Changing Payment Options

Payment options may be changed at any time. The effective date of any change is the date of the next scheduled payment based on Your new billing period. You can change Your payment option by visiting Our website at [deltadentalins.com](http://deltadentalins.com) or by contacting Our Customer Service Center toll-free at 888-282-8784.

## Grace Period on Late Payments

A grace period of 31 days will be granted for the payment of each Premium falling due after the first Premium. During this time this Policy will continue in force. If We do not receive payment at the end of the grace period, Your coverage will terminate effective the last day of the grace period.

Unpaid Premium: At the time of payment of a claim under this Policy, any Premium then due and unpaid or covered by any note or written order may be deducted from the payment.

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## **GENERAL PROVISIONS**

### **Entire Policy; Changes**

This Policy, with the application and Attachments, constitutes the entire contract of insurance between the parties. No change in this Policy will be valid unless approved by Our executive officer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

### **Severability**

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

### **Incontestability**

After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for this Policy will be used to void this Policy or to deny a claim for loss incurred or disability commencing after the expiration of such 2-year period.

No claim for loss incurred or disability commencing after two (2) years from the date of issue of this Policy will be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed prior to the Effective Date of this Policy.

### **Clinical Examination**

Before approving a claim, We will be entitled to receive, to such extent as may be lawful, information and records relating to the treatment provided to You as may be required to administer the claim. Examination may be required by a dental consultant retained by Us in or near Your community or residence. We will in every case hold such information and records confidential.

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## Written Notice of Claim/Proof of Loss

Proof of Loss: For a claim for loss for which this Policy provides any periodic payment contingent on continuing loss, a written proof of loss must be provided to Us at Our designated office before the 91<sup>st</sup> day after the termination of the period for which We are liable. For a claim for any other loss, a written proof of loss must be provided to Us at Our designated office before the 91<sup>st</sup> day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than once year after the time the proof is otherwise required, except in the event of a legal incapacity.

Send Your Notice of Claim/Proof of Loss to Us at the address shown below:

Delta Dental Insurance Company  
P.O. Box 1809  
Alpharetta, GA 30023-1809

## Claim Form

We will before the 16<sup>th</sup> day after receiving a notice of a claim provide You or Your Provider with a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to Us at the address above.

If We do not send You or Your Provider a Claim Form before the 16<sup>th</sup> day after You or Your Provider gave Us notice regarding a claim, the requirements for proof of loss outlined in the section “*Written Notice of Claim/Proof of Loss*” above will be deemed to have been complied with as long as You give Us written proof that explains the type and the extent of the loss that You are making a claim for within the time established for filing proofs of loss. You may also download a Claim Form from Our website at [deltadentalins.com](http://deltadentalins.com).

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## **Time of Payment**

Claims payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be processed immediately after written proof of loss is received in the form required by the terms of this Policy. We will notify You and Your Provider of any additional information needed to process the claim.

## **To Whom Benefits Are Paid**

It is not required that the service be provided by a specific Provider. Payment for services provided by a DPO or Premier Provider will be made directly to the Provider. Any other payments provided by this Policy will be made to You unless You request in writing when filing a proof of claim that the payment be made directly to the Provider providing the services. All Benefits not paid to the Provider will be payable to You or to Your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to the parent, guardian or other person actually supporting the individual.

## **Misstatements on Application; Effect**

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under this Policy, all statements made by You will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Policy unless it is contained in a written application. If any misstatement would materially affect the rates, We reserve the right to adjust the Premium to reflect Your actual circumstances at time of application or to terminate Your Policy. If Your age has been misstated, the amounts payable under this Policy are the amounts the Premium paid would have purchased at the correct age.

## **Legal Actions**

No action at law or in equity will be brought to recover on this Policy prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of this Policy. No action can be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by this Policy.

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## **Conformity with Applicable Laws**

All legal questions about this Policy will be governed by the state of Texas where this Policy was entered into and is to be performed. Any part of this Policy that conflicts with the laws of Texas or federal law is hereby amended to conform to the minimum requirements of such laws. If this Policy is not in conformity with Texas laws or other applicable laws, it will not be rendered invalid but will be construed and applied as if it were in full compliance with Texas law and other applicable laws. The remaining provisions are not invalidated by such change, and will remain in full force and effect.

## **Holding Company**

Delta Dental is a member of the insurance holding company system of Delta Dental of California (the "Enterprise"). There are service agreements between and among the controlled member companies of the Enterprise. Delta Dental is a party to some of these service agreements. It is expected that the services, which include certain ministerial tasks, will continue to be performed by these controlled member companies, which operate under strict confidentiality and/or business associate agreements. All such service agreements have been approved by the respective regulatory agencies.

## **Third Party Administrator ("TPA")**

We may use the services of a TPA, duly registered under applicable state law, to provide services under this Policy. Any TPA providing such services or receiving such information must enter into a separate business associate agreement with Us providing that the TPA will meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

## **Impossibility of Performance**

Neither party (Policyholder or Delta Dental) will be liable to the other or be deemed to be in breach of this Policy for any failure or delay in performance arising out of causes beyond its reasonable control. Such causes are strictly limited to include acts of God or of a public enemy, explosion, fires or unusually severe weather. Dates and times of performance will be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay.

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## 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, 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.

We:

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

If You need these services, contact Our Customer Service Center at 888-282-8784.

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.

Delta Dental  
P.O. Box 997330  
Sacramento, CA 95899-7330  
Telephone Number: 888-282-8784  
Website Address: [deltadentalins.com](http://deltadentalins.com)

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

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

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

## Attachment A Deductibles, Maximums and Policy Benefit Levels

<b>Deductibles &amp; Maximums</b>	
<b>Annual Deductible<sup>1</sup></b>	\$50 per Enrollee each Calendar Year \$150 per family each Calendar Year
<b>Deductible waived for</b>	Diagnostic and Preventive Services
<b>Annual Maximum</b>	\$1,000 per Enrollee per Calendar Year

<b>Policy Benefit Levels<sup>2</sup></b>		
<b>Dental Service Category</b>	<b>DPO from Delta Dental Providers</b>	<b>Delta Dental Premier and Non-Delta Dental Providers</b>
<b>Diagnostic and Preventive Services</b>	100%	100%
<b>Basic Services</b>	50%	50%
<b>Waiting Periods</b>	Basic Services are limited to Enrollees who have been covered under this Policy for 6 consecutive months. <sup>3</sup>	

<sup>1</sup> Annual Deductible applies to all service categories except Diagnostic and Preventive Services. Benefits will apply after the annual Deductible is satisfied.

<sup>2</sup> Delta Dental will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for covered services. Note: While Delta Dental will pay the same Policy Benefit Level for covered services performed by a DPO Provider, Premier Provider and a Non-Delta Dental Provider, the amount charged to Enrollees for covered services performed by a Premier Provider or Non-Delta Dental Provider may be above that accepted by DPO Providers, and Enrollees will be responsible for balance-billed amounts.

<sup>3</sup> Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from his or her own effective date of coverage. No exceptions or credits are given for prior coverage provided under any plan.

## **Attachment B Services, Limitations and Exclusions**

### **Description of Dental Services**

We will pay or otherwise discharge the Policy Benefit Level shown in Attachment A for the following services:

- **Diagnostic and Preventive Services**

- (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
- (2) Preventive: cleaning, including scaling in presence of generalized moderate or severe gingival inflammation – full mouth, topical application of fluoride solutions, space maintainers.
- (3) Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

- **Basic Services**

- (1) Palliative: emergency treatment to relieve pain.
- (2) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated crowns for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- (3) Oral Surgery: extraction of erupted teeth.
- (4) Endodontics: therapeutic pulpotomy and pulpal therapy.



- **Note on additional Benefits during pregnancy**

When an Enrollee is pregnant, We will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Policy include one (1) additional oral exam and one (1) additional routine cleaning. Written confirmation of the pregnancy must be provided by the Enrollee or the Enrollee's Provider when the claim is submitted.

- **Teledentistry Services**

Teledentistry services are dental services delivered by a dentist acting within the scope of the dentist's license, or by a health professional acting under the dentist's delegation and supervision and within the scope of the health professional's license or certification. Teledentistry services use telecommunications and information technology to deliver the services to an Enrollee in one physical location while the dentist or health professional is located in a different physical location. We cover Teledentistry services the same as services provided in an in-office visit.

## **Limitations**

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

Examples of Optional Services:

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

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

- (2) Exam and cleaning limitations:
- a) We will pay for oral examinations (except after-hours exams and exams for observation) and cleanings, including scaling in presence of generalized moderate or severe gingival inflammation no more than twice in a Calendar Year.
  - b) Caries risk assessments are allowed once in 12 months.
- (3) Image limitations:
- a) We will limit the total reimbursable amount to the Provider's Accepted Fee for a comprehensive intraoral series of radiographic images when the fees for any combination of intraoral images in a single treatment series meet or exceed the Accepted Fee for a comprehensive intraoral series.
  - b) Benefits are limited to either one (1) comprehensive intraoral series or one (1) panoramic image once every 60 months.
  - c) If a panoramic image is taken in conjunction with a comprehensive intraoral series, We will limit reimbursement to the Provider's Accepted Fee for the comprehensive intraoral series, and the fee for the panoramic image will be the responsibility of the Enrollee.
  - d) Panoramic images are not considered part of a comprehensive intraoral series.
  - e) Bitewing images are limited to two (2) times per Calendar Year when provided to Enrollees under age 18 and one (1) time per Calendar Year for Enrollees age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

- f) Bitewing images of any type are included in the fee of a comprehensive series when taken within 6 months of the comprehensive images.
  - g) Bitewing images are limited to two images for under age 10.
  - h) Image capture procedures are not separately billable services.
- (4) Cone beam CT capture and interpretation are covered not more than once in any 12 month period. Interpretation of a diagnostic image only is covered for cone beam services. Cone beam interpretation is a covered Benefit when provided by a different dentist/dental office than the dentist/dental office who provided the cone beam capture only services.
- (5) Topical application of fluoride solutions is limited to Enrollees to age 19 and no more than twice in a Calendar Year.
- (6) Application of caries arresting medicament is limited to twice per tooth per Calendar Year.
- (7) Space maintainer limitations:
- a) Except for distal shoe space maintainers, space maintainers are limited to the initial appliance and are a Benefit for an Enrollee to age 14.
  - b) A distal shoe space maintainer - fixed - unilateral is limited to children 8 and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
  - c) Recementation of space maintainer is limited to once per lifetime.
  - d) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.
- (8) Pulp vitality tests are allowed once per day when definitive treatment is not performed.

- (9) Sealants are limited as follows:
  - a) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without caries (decay) or restorations on the occlusal surface.
  - b) repair or replacement of a sealant on any tooth within 24 months of its application is included in the fee for the original placement.
- (10) Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a 12-month period and included if reported, with any other examination on the same date of service and Provider office.
- (11) We will not cover replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.
- (12) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- (13) Prefabricated crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16. Replacement restorations within 24 months are included in the fee for the original restoration.
- (14) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
- (15) Pulpal therapy (resorbable filling) is limited to once in a lifetime.
- (16) Pin retention is covered not more than once in any 24-month period.
- (17) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required images or select diagnostic procedures.

- (18) Cleanings (regular and periodontal) are subject to a 30-day wait following periodontal scaling and root planing if performed by the same Provider office.
- (19) Oral surgery services for the extraction of an erupted tooth or exposed root are covered once in a lifetime per tooth.
- (20) The fees for synchronous/asynchronous Teledentistry services are considered inclusive in overall patient management and are not a separately payable service.

## **Exclusions**

### **We do not pay Benefits for:**

- (1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- (2) cosmetic surgery or procedures for purely cosmetic reasons.
- (3) maxillofacial prosthetics.
- (4) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
- (5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.

- (6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or night guards/occlusal guards and abfraction.
- (7) any Single Procedure provided prior to the date You became eligible for services under this Plan.
- (8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- (9) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia and regional/or trigeminal block anesthesia are not separately payable procedures.
- (10) extraoral grafts (grafting of tissues from extraoral sites in the Enrollee's own body to oral tissues).
- (11) laboratory processed crowns for Enrollees under age 12.
- (12) fixed bridges and removable partials for Enrollees under age 16.
- (13) interim implants.
- (14) indirectly fabricated resin-based inlays/onlays.
- (15) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- (16) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- (17) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, image duplications, cancer screening, tobacco counseling or broken appointments.

- (18) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- (19) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- (20) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.
- (21) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.
- (22) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- (23) services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the orthodontic services section, if applicable.
- (24) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues) except as provided under the TMJ Benefit section, if applicable.
- (25) services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.
- (26) services or supplies for oral surgery, general anesthesia or IV sedation, other than extraction of an erupted tooth or exposed root.
- (27) services or supplies for endodontic treatment (procedures for removal of the nerve of the tooth and the treatment of the pulp cavity portion of the root of the tooth), other than therapeutic pulpotomy and pulpal therapy.

- (28) services or supplies for periodontic treatment (procedures for the treatment of the gums and the bones supporting teeth).
- (29) services or supplies for denture repairs (repair to partial or complete dentures including rebase procedures and relining).
- (30) services or supplies for crowns and onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composite restorations.
- (31) services or supplies for prosthodontics (procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges).
- (32) missed and/or cancelled appointments.
- (33) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- (34) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- (35) dental case management motivational interviewing and patient education to improve oral health literacy.
- (36) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- (37) extraoral - 2D projection radiographic image and extraoral posterior dental radiographic image.
- (38) diabetes testing.
- (39) antigen or antibody testing.
- (40) counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.
- (41) services or supplies for sleep apnea.
- (42) cone beam image capture only is not a covered Benefit.





Delta Dental Insurance Company  
One Delta Drive  
Mechanicsburg, PA 17055-6999  
888-282-8784  
deltadentalins.com

## Delta Dental Individual & Family™

DPO from Delta Dental  
Basic Plan for Families

### Outline of Coverage

Read Your Policy carefully. This outline of coverage provides a very brief description of the important features of Your Policy. This is not the insurance Policy and only the Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is therefore important that You **READ YOUR POLICY CAREFULLY**. The Policy provides Benefits for dental care only. It does not pay Benefits for any other type of loss such as medical or hospital expenses.

If You are not satisfied with the Policy for any reason, You may return the Policy within 10 days after You receive it. Mail or deliver it to Delta Dental Insurance Company ("Delta Dental"). Any Premium paid will be refunded. The Policy will then be void from its start.

**IMPORTANT:** In the event of any inconsistency between this outline of coverage and the Policy, the terms of the Policy will control.

## Deductibles, Maximums and Policy Benefit Levels

<b>Deductibles &amp; Maximums</b>	
<b>Annual Deductible<sup>1</sup></b>	\$50 per Enrollee each Calendar Year \$150 per family each Calendar Year
<b>Deductible Waived for</b>	Diagnostic and Preventive Services
<b>Annual Maximum</b>	\$1,000 per Enrollee per Calendar Year

<b>Policy Benefit Levels<sup>2</sup></b>		
<b>Dental Service Category</b>	<b>DPO from Delta Dental Providers</b>	<b>Delta Dental Premier and Non-Delta Dental Providers</b>
<b>Diagnostic and Preventive Services</b>	100%	100%
<b>Basic Services</b>	50%	50%
<b>Waiting Periods</b>	Basic services are limited to Enrollees who have been covered under this Policy for 6 consecutive months. <sup>3</sup>	

- <sup>1</sup> Annual Deductible applies to all service categories except diagnostic and preventive services. Benefits will apply after the annual Deductible is satisfied.
- <sup>2</sup> We will pay or otherwise discharge the Policy Benefit Level according to the Maximum Contract Allowance for covered services. Note: While We will pay the same Policy Benefit Level for covered services performed by a DPO Provider, Premier Provider and a Non-Delta Dental Provider, the amount charged to You for covered services performed by a Premier Provider or Non-Delta Dental Provider may be above that accepted by DPO Providers, and You will be responsible for balance-billed amounts.
- <sup>3</sup> Waiting Periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Enrollee’s effective date of coverage. No exceptions or credits are given for prior coverage provided under any plan.

## Limitations

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

Examples of Optional Services:

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

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

- (2) Exam and cleaning limitations:
- a) We will pay for oral examinations (except after-hours exams and exams for observation) and cleanings, including scaling in presence of generalized moderate or severe gingival inflammation no more than twice in a Calendar Year.
  - b) Caries risk assessments are allowed once in 12 months.
- (3) Image limitations:
- a) We will limit the total reimbursable amount to the Provider’s Accepted Fee for a comprehensive intraoral series of radiographic images when the fees for any combination of intraoral images in a single treatment series meet or exceed the Accepted Fee for a comprehensive intraoral series.

- b) Benefits are limited to either one (1) comprehensive intraoral series or one (1) panoramic image once every 60 months.
  - c) If a panoramic image is taken in conjunction with a comprehensive intraoral series, We will limit reimbursement to the Provider's Accepted Fee for the comprehensive intraoral series, and the fee for the panoramic image will be the responsibility of the Enrollee.
  - d) Panoramic images are not considered part of a comprehensive intraoral series.
  - e) Bitewing images are limited to two (2) times per Calendar Year when provided to Enrollees under age 18 and one (1) time per Calendar Year for Enrollees age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
  - f) Bitewing images of any type are included in the fee of a comprehensive series when taken within 6 months of the comprehensive images.
  - g) Bitewing images are limited to two images for under age 10.
  - h) Image capture procedures are not separately billable services.
- (4) Cone beam CT capture and interpretation are covered not more than once in any 12 month period. Interpretation of a diagnostic image only is covered for cone beam services. Cone beam interpretation is a covered Benefit when provided by a different dentist/dental office than the dentist/dental office who provided the cone beam capture only services.
- (5) Topical application of fluoride solutions is limited to Enrollees to age 19 and no more than twice in a Calendar Year.
- (6) Application of caries arresting medicament is limited to twice per tooth per Calendar Year.
- (7) Space maintainer limitations:
- a) Except for distal shoe space maintainers, space maintainers are limited to the initial appliance and are a Benefit for an Enrollee to age 14.

- b) A distal shoe space maintainer - fixed - unilateral is limited to children 8 and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
  - c) Recementation of space maintainer is limited to once per lifetime.
  - d) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.
- (8) Pulp vitality tests are allowed once per day when definitive treatment is not performed.
- (9) Sealants are limited as follows:
- a) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without caries (decay) or restorations on the occlusal surface.
  - b) repair or replacement of a sealant on any tooth within 24 months of its application is included in the fee for the original placement.
- (10) Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a 12-month period and included if reported, with any other examination on the same date of service and Provider office.
- (11) We will not cover replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.
- (12) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- (13) Prefabricated crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16. Replacement restorations within 24 months are included in the fee for the original restoration.

- (14) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
- (15) Pulpal therapy (resorbable filling) is limited to once in a lifetime.
- (16) Pin retention is covered not more than once in any 24-month period.
- (17) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required images or select diagnostic procedures.
- (18) Cleanings (regular and periodontal) are subject to a 30-day wait following periodontal scaling and root planing if performed by the same Provider office.
- (19) Oral surgery services for the extraction of an erupted tooth or exposed root are covered once in a lifetime per tooth.
- (20) The fees for synchronous/asynchronous Teledentistry services are considered inclusive in overall patient management and are not a separately payable service.

## **Exclusions**

### **We do not pay Benefits for:**

- (1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- (2) cosmetic surgery or procedures for purely cosmetic reasons.
- (3) maxillofacial prosthetics.
- (4) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.

- (5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
- (6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or night guards/occlusal guards and abfraction.
- (7) any Single Procedure provided prior to the date You became eligible for services under this Plan.
- (8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- (9) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
- (10) extraoral grafts (grafting of tissues from extraoral sites in the Enrollee's own body to their oral tissues).
- (11) laboratory processed crowns for Enrollees under age 12.
- (12) fixed bridges and removable partials for Enrollees under age 16.
- (13) interim implants.
- (14) indirectly fabricated resin-based inlays/onlays.
- (15) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- (16) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

- (17) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, image duplications, cancer screening, tobacco counseling or broken appointments.
- (18) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- (19) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- (20) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.
- (21) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.
- (22) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- (23) services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the orthodontic services section, if applicable.
- (24) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues) except as provided under the TMJ Benefit section, if applicable.
- (25) services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.
- (26) services or supplies for oral surgery, general anesthesia or IV sedation, other than extraction of an erupted tooth or exposed root.



- (27) services or supplies for endodontic treatment (procedures for removal of the nerve of the tooth and the treatment of the pulp cavity portion of the root of the tooth), other than therapeutic pulpotomy and pulpal therapy.
- (28) services or supplies for periodontic treatment (procedures for the treatment of the gums and the bones supporting teeth).
- (29) services or supplies for denture repairs (repair to partial or complete dentures including rebase procedures and relining).
- (30) services or supplies for crowns and onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composite restorations.
- (31) services or supplies for prosthodontics (procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges).
- (32) missed and/or cancelled appointments.
- (33) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- (34) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- (35) dental case management motivational interviewing and patient education to improve oral health literacy.
- (36) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- (37) extraoral - 2D projection radiographic image and extraoral posterior dental radiographic image.
- (38) diabetes testing.
- (39) antigen or antibody testing.
- (40) counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.
- (41) services or supplies for sleep apnea.
- (42) cone beam image capture only is not a covered Benefit.

**Renewal:**

You may keep the Policy in force by timely payment of Premiums. However, We may refuse renewal due to:

- You fail to pay Premiums as required under the Policy;
- You have performed an act or practice that constitutes fraud, or have made a misrepresentation of material fact relating to the Policy;
- You fail to comply with material provisions of the Policy;
- We stop issuing the Policy in Texas, but only if We notify You in advance; or
- You no longer reside, live or work in Our service area.

Renewal Premiums are subject to change. We will provide 60 days advance written notice of any change in Premium at renewal.

**Grace Period on Late Payments:**

A grace period of 31 days will be granted for the payment of each Premium falling due after the first Premium. During this time the Policy will continue in force. If We do not receive payment at the end of the grace period, Your coverage will terminate effective the last day of the grace period. Unpaid Premium: At the time of payment of a claim under the Policy, any Premium then due and unpaid or covered by any note or written order may be deducted from the payment.

**Plan Premium Information:**

Each Enrollee Age 0-17:	\$19.44 per month \$58.32 per quarter \$233.28 annually
Each Enrollee Age 18 or older:	\$21.91 per month \$65.73 per quarter \$262.92 annually



deltadentalins.com

## **HIPAA Notice of Privacy Practices**

### **CONFIDENTIALITY OF YOUR HEALTH INFORMATION**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our privacy practices reflect applicable federal law as well as state law. The privacy laws of a particular state or other federal laws might impose a stricter privacy standard. If these stricter laws apply and are not superseded by federal preemption rules under the Employee Retirement Income Security Act of 1974, the Plans will comply with the stricter law.

We are required by law to maintain the privacy and security of your Protected Health Information (PHI). Protected Health Information (PHI) is information that is maintained or transmitted by Delta Dental, which may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. We receive, use and disclose your PHI to administer your benefit plan as permitted or required by law.

We must follow the federal and state privacy requirements described that apply to our administration of your benefits and provide you with a copy of this notice. We reserve the right to change our privacy practices when needed and we promptly post the updated notice within 60 days on our website.

## **PERMITTED USES AND DISCLOSURES OF YOUR PHI**

### **Uses and disclosures of your PHI for treatment, payment or health care operations**

Your explicit authorization is not required to disclose information for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. Examples of this include processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers, determine your eligibility for services, billing you or your plan sponsor.

If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or plan sponsor to administer your benefits. As permitted by law, we may disclose PHI to third-party affiliates that perform services on our behalf to administer your benefits. Any third-party affiliates performing services on our behalf has signed a contract agreeing to protect the confidentiality of your PHI and has implemented privacy policies and procedures that comply with applicable federal and state law.

### **Permitted uses and disclosures without an authorization**

We are permitted to disclose your PHI upon your request, or to your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human

Services to investigate or determine our compliance with the law, and when otherwise required by law. We may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Some other examples include: to notify or assist in notifying a family member, another person, or a personal representative of your condition; to assist in disaster relief efforts; to report victims of abuse, neglect or domestic violence to appropriate authorities; for organ donation purposes; to avert a serious threat to health or safety; for specialized government functions such as military and veterans activities; for workers' compensation purposes; and, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting, provided it does not contain genetic information. Information can also be de-identified or summarized so it cannot be traced to you and, in selected instances, for research purposes with the proper oversight.

### **Disclosures made with your authorization**

We will not use or disclose your PHI without your prior written authorization unless permitted by law. If you grant an authorization, you can later revoke that authorization, in writing, to stop the future use and disclosure.

## **YOUR RIGHTS REGARDING PHI**

### **You have the right to request an inspection of and obtain a copy of your PHI.**

You may access your PHI by providing a written request. Your request must include (1) your name, address, telephone number and identification number, and (2) the PHI you are requesting. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We will only maintain PHI that we obtain or utilize in providing your health care benefits. We may not maintain some PHI, such as treatment records or x-rays after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that we do not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed.

### **You have the right to request a restriction of your PHI.**

You have the right to ask that we limit how we use and disclose your PHI; however, you may not restrict our legal or permitted uses and disclosures of PHI. While we will consider your request, we are not legally required to accept those requests that we cannot reasonably implement or comply with during an emergency.

**You have the right to correct or update your PHI.**

You may request to make an amendment of PHI we maintain about you. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal within 60 days. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your provider to amend your treatment chart or to your employer, if applicable, to amend your enrollment information.

**You have rights related to the use and disclosure of your PHI for marketing.**

We will obtain your authorization for the use or disclosure of PHI for marketing when required by law. You have the right to withdraw your authorization at any time. We do not use your PHI for fundraising purposes.

**You have the right to request or receive confidential communications from us by alternative means or at a different address.**

You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.**

You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes

of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons, certain law enforcement purposes or disclosures made as part of a limited data set. We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another accounting within 12 months.

**You have the right to a paper copy of this notice.**

A copy of this notice is posted on our website. You may also request that a copy be sent to you.

**You have the right to be notified following a breach of unsecured protected health information.**

We will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

**You have the right to choose someone to act for you.**

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

**COMPLAINTS**

You may file a complaint with us and/or with the U.S. Secretary of Health and Human Services if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.



## **CONTACTS**

You may contact us by calling 866-530-9675, or you may write to the address listed below for further information about the complaint process or any of the information contained in this notice.

Delta Dental  
PO Box 997330  
Sacramento, CA 95899-7330

This notice is effective on and after March 1, 2019.

Our Delta Dental PPO plans are underwritten by these companies in these states: California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT. DeltaCare USA is underwritten in these states by these companies: 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. DeltaVision is underwritten by these companies in these states: Delta Dental of California — CA; Delta Dental Insurance Company — AL, DE, DC, FL, GA, LA, MD, MT, NV, NY, PA, TX, UT and WV. DeltaVision is administered by Vision Service Plan (VSP).

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 1-866-530-9675 (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 1-866-530-9675 (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 1-866-530-9675 (TTY: 711)。(Chinese)

Bạn có đọc được tài liệu này không? Nếu không, chúng tôi sẽ cử một ai đó giúp bạn đọc. Bạn cũng có thể nhận được tài liệu này viết bằng ngôn ngữ của bạn. Để nhận được trợ giúp miễn phí, vui lòng gọi 1-866-530-9675 (TTY: 711). (Vietnamese)

이 문서를 읽으실 수 있습니까? 읽으실 수 없으면 다른 사람이 대신 읽어드릴 수 있습니다. 한국어로 번역된 문서를 받으실 수도 있습니다. 무료로 도움을 받기를 원하시면 1-866-530-9675 (TTY: 711)번으로 연락하십시오. (Korean)

Nababasa mo ba ang dokumentong ito? Kung hindi, may tao kaming makakatulong sa iyong basahin ito. Maaari mo ring makuha ang dokumentong ito nang nakasulat sa iyong wika. Para sa libreng tulong, pakitawagan ang 1-866-530-9675 (TTY: 711). (Tagalog)

Вы можете прочитать этот документ? Если нет, мы можем предоставить вам кого-нибудь, кто поможет вам прочитать его. Вы также можете получить этот документ на своем языке. Для получения бесплатной помощи, просьба звонить по номеру 1-866-530-9675 (телетайп: 711). (Russian)

هل تستطيع قراءة هذا المستند؟ إذا كنت لا تستطيع، يمكننا أن نوفر لك من يساعدك في قراءتها. ربما يمكنك أيضًا للحصول على هذا المستند تكموبًا بلغتك للمساعدة المجانية اتصل بـ 1-866-530-9675 (TTY: 711). (Arabic)

Èske w ka li dokiman sa a? Si w pa kapab, nou ka fè yon moun ede w li l. Ou ka gen posiblite pou jwenn dokiman sa a tou ki ekri nan lang ou. Pou jwenn èd gratis, tanpri rele 1-866-530-9675 (TTY: 711). (Haitian Creole)

Pouvez-vous lire ce document ? Si ce n'est pas le cas, nous pouvons faire en sorte que quelqu'un vous aide à le lire. Vous pouvez également obtenir ce document écrit dans votre langue. Pour obtenir de l'assistance gratuitement, veuillez appeler le 1-866-530-9675 (TTY : 711). (French)

Możesz przeczytać ten dokument? Jeśli nie, możemy Ci w tym pomóc. Możesz także otrzymać ten dokument w swoim języku ojczystym. Po bezpłatną pomoc zadzwoń pod numer 1-866-530-9675 (TTY: 711). (Polish)

Você consegue ler este documento? Se não, podemos pedir para alguém ajudá-lo a ler. Você também pode receber este documento escrito em seu idioma. Para obter ajuda gratuita, ligue 1-866-530-9675 (TTS: 711). (Portuguese)

Non riesci a leggere questo documento? In tal caso, possiamo chiedere a qualcuno di aiutarti a farlo. Potresti anche ricevere questo documento scritto nella tua lingua. Per assistenza gratuita, chiama il numero 1-866-530-9675 (TTY: 711). (Italian)

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آیا می توانید این متن را بخوانید؟ در صورتی که نمی توانید، ما قادریم از شخصی بخواهیم تا در خواندن این متن به شما کمک کند. همچنین ممکن است بتوانید این متن را به زبان خود دریافت کنید. برای کمک رایگان با این شماره تماس بگیرید: 1-866-530-9675 (TTY: 711). (Persian Farsi)

क्या आप इस दस्तावेज़ को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी सहायता करने हेतु किसी की व्यवस्था कर सकते हैं। आप इस दस्तावेज़ को अपनी भाषा में लिखा हुआ भी प्राप्त कर सकते हैं। निशुल्क सहायता के लिए, कृपया यहाँ कॉल करें 1-866-530-9675 (TTY: 711)। (Hindi)

คุณสามารถอ่านเอกสารนี้ได้หรือไม่? หากไม่ได้ เราสามารถหาคนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถรับเอกสารนี้ที่เขียนในภาษาของคุณได้อีกด้วย ได้รับความช่วยเหลือฟรีได้โดยโทรไปที่ 1-866-530-9675 (TTY: 711) (Thai)

ਕੀ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰਨ ਲਈ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਲਿਆ ਸਕਦੇ ਹਾਂ। ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ। ਮੁਫਤ ਵਿੱਚ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-866-530-9675 (TTY: 711) ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Դուք կարող եք կարդալ այս փաստաթուղթը: Եթե ոչ, մենք որևէ մեկին կգտնենք, ով կօգնի ձեզ կարդալ: Դուք կարող եք նաև այս փաստաթուղթը ստանալ գրաված ձևով: Անվճար օգնություն համար ինդրոնթեքստը կապահովելու համար 1-866-530-9675 (TTY: 711): (Armenian)

Koj nyeem puas tau daim ntawv no? Yog koj nyeem tsis tau, peb muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, tej zaum kuj muab daim ntawv no sau ua koj hom lus tau thiab. Yog yuav thov kev pab dawb, thov hu rau 1-866-530-9675 (TTY: 711). (Hmong)

តើលោកអ្នកអាចអានឯកសារនេះបានទេ? បើសិនមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់ជួយអានឱ្យលោកអ្នក។ លោកអ្នកក៏អាចទទួលបានឯកសារនេះជាលាយលក្ខណ៍អក្សរជាភាសារបស់លោកអ្នកផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-866-530-9675 (TTY: 711)។ (Cambodian)

צ קענט איר לייענען דעם דאזיקן דאקומנט? אויב ניט, עמעצער דא קען איך העלפן אים צו לייענען. עס איז אויך מעגלעך, אז איר קענט באקומען דעם דאזיקן דאקומענט אין איינער שפראך. פאר אומזיסטע הילף קענט איר אנקלינגען אַט די דאזיקע נומער: 1-866-530-9675 ס'איז דא א נומער פאר מענטשען, וואס הערן ניט: 711 (Yiddish)

Díísh yíníłta'go bííníghah? Doo bííníghahgóó éí nich'í' yídóolta'hígíí nihee hóóló. Díí naaltsoos t'áá Diné bizaad k'éhjí ályaago ałdó' nich'í' ádoolnǫ́łgo bííghah. T'áá jíík'e shíká i'doolwoł nínízingo kojí' béésh holdílnih 1-866-530-9675 (TTY: 711) (Navajo)

## **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.

Delta Dental  
PO Box 997330  
Sacramento, CA 95899-7330  
1-866-530-9675  
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.

Our Delta Dental PPO plans are underwritten by these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT. DeltaCare USA is underwritten in these states by these companies: 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. DeltaVision is underwritten by these companies in these states: Delta Dental of California — CA; Delta Dental Insurance Company — AL, DE, DC, FL, GA, LA, MD, MT, NV, NY, PA, TX, UT, and WV. DeltaVision is administered by Vision Service Plan (VSP).

## ENROLLEE NOTICES

Federal and state laws require enrollees to be notified on a periodic basis about enrollee rights and privacy practices. Below is a summary of the notices that are available under the legal or privacy section of our webpage. To access the most current version and the full text of each notice, please visit our website at [deltadentalins.com](http://deltadentalins.com).

### Federal Notices:

- **HIPAA Notice of Privacy Practices (NPP):** Federal regulations require insurance plans to share information about the company's privacy practices. This is called a "Notice of Privacy Practices (NPP)" and should be read when an individual first becomes an enrollee and reviewed at least every three years thereafter.
- **Gramm-Leach-Bliley (GLB):** Financial institutions and insurance companies must describe how demographic and financial information is collected and shared. California requires a state specific notice called the California Financial Privacy Notice, which is described below under the State Notices section.
- **Notice of 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, including sex stereotypes and gender identity. If you believe 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.

- **Language Assistance Notice and Survey:** We provide phone interpretation to callers who do not speak English. In California, we will also provide, on request, a translated copy of certain vital documents in either Spanish or Chinese. In Maryland and Washington DC, enrollees may receive grievance materials in Spanish or Chinese.

### State Notices:

- **CA Financial Privacy Notice:** This notice to Californians describes our demographic and financial information collection and sharing practices. It is similar to the Gramm-Leach-Bliley (GLB) notice described above.
- **CA Grievance Process:** This notice describes our procedure for processing and resolving enrollee grievances and gives the address and phone number to make a complaint. Californians are encouraged to read this notice when they first enroll and annually thereafter.
- **CA Timely Access to Care:** California law requires health plans to provide timely access to care. This law sets limits on how long enrollees must wait to get appointments and telephone assistance.
- **CA Tissue and Organ Donations:** This notice informs subscribers of the societal benefits of organ donation and the methods they can use to become organ and/or tissue donors. California regulations require every health plan to provide this information upon enrollment and annually thereafter.





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- **CA Annual Deductible and OOP Max Accrual Balances:** California law requires health plans to provide enrollees with up-to-date accrual balances towards their annual deductible and out-of-pocket maximum for every month benefits were used until the accrual balances are met. Enrollees have the right to request their most up-to-date accrual balance from the health plan at any time.
- **CA Request Confidential Communications:** This notice informs subscribers of methods of contacting the plan when there is a need or desire to provide and alternative address to received protected health information. Users may also choose to use the “Request for Confidential Communication” form when submitting such request.

For questions concerning the notices, please contact us at 866-530-9675. You may also write to us at:

Delta Dental  
PO Box 997330  
Sacramento, CA 95899-7330

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